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Rehabilitation Literature is intended for use by professional personnel and students in all disciplines concerned with rehabilitation of the handicapped. It is dedicated to the advancement of knowledge and skills and to the encouragement of cooperative efforts by professional members of the rehabilitation team. Goals are to promote communication among workers and to alert each to the literature on development and progress both in his own area of responsibility and in related areas.

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REHABILITATION LITERATURE

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Dr. Edward E. Gordon Comments on

More Training for Nurses in Rehabilitation

"THE NURSE is often omitted from reckoning when thinking of the rehabilitation team. She is more than ever the handmaiden to medicine in the new context of comprehensive long-term care. Although a beginning has been made in rehabilitation nursing, the practice has hardly permeated from a few foci in this country. Nursing schools give the subject little or no attention in their curriculum. Yet the nurse is of enormous importance. She is the constant attendant to the patient, the guide, the listening post. In rehabilitation her job, as Dr. Howard Rusk stated, is to help the patient help himself. I have a suspicion, which I hope to be able to put to a test soon, that in the majority of the aged and in many of the disabled a good nurse trained in rehabilitation and diffusing encouragement, interest, and sympathy is worth one physical therapist and one occupational therapist. This is not to undersell the therapies. Stated biologically, the problem is this: Can most people in a hospital attain self-care with minimal but well-directed effort equal to that attained after an intensive, massive effort represented by the team approach? This is the basic question concerning the methodology of rehabilitation. If it can be shown that one well-trained nurse can accomplish a high degree of success, this demonstration will have far-reaching effects upon cost of comprehensive care as well as upon the future of nursing. Meanwhile, the present nurse can contribute enormously if she would only adopt certain well-known rehabilitation procedures as her own: To be specific, preventive positioning against secondary deformity in the acute phase; modern procedures of bladder control training; early ambulation and earlier movement of parts to prevent thrombosis, deconditioning, and general deterioration; familiarity with self-help devices combined with an alertness to provide them. And many others. The nurse will, therefore, be the backbone of the long-term-care phase.

"The nursing profession can contribute more. That peripatetic nurse, who travels about the community to visit and minister to the sick at home, can become a powerful link in the chain of activities required for rehabilitation. She could strengthen home programs by bringing certain skills and knowledge now regarded only as the property of departments of rehabilitation in hospitals and other centers. Trained in principles of exercise, self-care, self-help devices, along with the more traditional nursing techniques, she takes her place in the home as the counterpart of the ward rehabilitation nurse in programs for comprehensive care. To those who may object that occupational therapy is for the occupational therapist and physical therapy is for the physical therapist only, I say that it makes no difference who does the work of the Lord. Besides, to carry out comprehensive care in the home, the home must be seen at first hand —for the physical as well as the social aspects. As they are in a strategic position to do this, public health nurses and visiting nurses should become familiar also with techniques of physical rehabilitation."—*Edward E. Gordon, M.D., in "Chronic Disease and Disability: a Public Health Responsibility,"* Public Aid in Illinois, *May 1959, p. 6, 12.*

REHABILITATION LITERATURE

Article of the Month

Work and the Social Life of the Handicapped

E. Louise Ware, Ph.D.

About the Author . . .

Dr. E. Louise Ware is Professor and Chairman of the Sociology Department of Adelphi College and a consultant on two rehabilitation research projects at the Research Foundation for Mental Hygiene, New York State Department of Mental Hygiene. She was formerly a consultant in mental hygiene, Association for the Aid of Crippled Children, New York City. From 1955 to 1958 Dr. Ware was director of the interdisciplinary rehabilitation research project conducted at Adelphi College, under a grant from the U.S. Office of Vocational Rehabilitation. She is the author of two biographies; her other writings include pamphlets and articles. Dr. Ware is a member of the American Sociological Society and the Eastern Sociological Society.

In recent years a great deal of thought has been directed toward the place that the individual holds in our society, to the various aspects of his social role in his home, on the job, and in the community at large. Much related consideration, too, has been given to the sociology of occupations—to the meaning of work for the individual and to the relation of work to central life interests.

The Industrial Worker in General

In line with this present-day emphasis, the worker in industry has come in for a considerable amount of attention. Numerous studies have shed light upon the manner of person that he is, upon his leisuretime activities, his relationships with fellow workmen, his home life, and his connection with neighbors and other friends.

The life of an individual is made up of many parts blended together: his cultural heritage; his life history; the people of his past; the places where he has lived—whether as a neighbor or as a stranger; his planes of living and his wished for standards; the prestige accorded him as a member of his community. These aspects of life and relationship make their imprint upon him and they form the background for the value system of social codes and rituals out of which he operates.

Values. It is believed that the patterns of the industrial worker in the main reflect the values of the great middle grouping in our society. Often cited as secular values of these particular folk is a cluster of sustaining codes, including: allegiance to family; responsibility for self-support; respectability; maintenance of one's own abode; pride in personal appearance and cleanliness; striving for one's goals; ambition for one's children; and planning for a brighter future. Sacred values are concerned with maintaining the right to one's spiritual beliefs, to living a life of the good and the humane.

Suburban Values. With many industrial workers coming to live in the suburban community, the general social codes are complemented by additional values. The desire to "be somebody," which exists in any setting, takes on a new and highly personalized note in the intimacy of the suburban neighborhood. Here "keeping up with the Joneses" is a prestige code acute in its poignancy. The modest Cape Cod home undergoing amortization; the ownership of a car; purchases of large bags of provisions at the supermarket; the power lawn mower, the velvet lawn, the azaleas and shrubs—all these are indicators of the special ways of life of those workers who live on the fringe of the city and are getting their roots down in the new community and relating their life to suburban industry. Preoccupation with these values, the changing interests of the family in the neighborhood—these diversions have eaten into the former devotion to the social life as it was once lived at the plant. Central life interests may or may not any longer have their hub in the factory but rather may be centered in the family pursuits and in the community. However, it is hypothesized that the enjoyments of suburban living may be influencing the kind of life and relationships at the job. Satisfactions may lead to new human contacts with fellow workers.

It is with the framework in mind of the ways of life of the industrial worker in general that one turns to the consideration of the handicapped worker, his social life, and his roles at the job and in his community. It is believed that his values are identified with those of his nonhandicapped fellow workman.

The Worker With a Handicap

In earlier days, the average person with physical handicaps found it difficult, if not impossible, to obtain a job in industry. Even when he had some skills to offer, the employer was reluctant to hire him, so great was the fear that he might hurt himself at the machines or that he might not measure up to the needs of the plant. Then, too, worry was constantly present lest the company become liable for second injuries believed certain to result. Now and then, however, an employer gave in and accepted the impaired applicant for work at the bench. In the years since World War II there has been a noteworthy increase in the hiring of the handicapped, brought about partly by the growing awareness of the public that the disabled worker need not be barred from his place in gainful work.

The Rehabilitation Continuum. At the present time a continuum exists in the rehabilitation of persons who have some form of impairment—a continuum that consists of several parts: medical evaluation, treatment, training or retraining; experiences in sheltered workshops; work in special shops; and work in open competitive industry. For those industrially inclined persons whose disability permits, it is generally believed that open industry is the sought for goal. Each of the parts of the continuum has an important place, however, in helping the worker to achieve his objective of gainful employment, or in enabling him to make the most of his abilities, whatever the setting.

The Adelphi College Study*

To consider the social life of the handicapped worker in Long Island, it was decided to make a study. From June, 1955, to June, 1958, the Adelphi College Graduate Division, under a grant from the U. S. Office of Vocational Rehabilitation, conducted an interdisciplinary sociological study, "Some Social Factors in Job Placement and Community Life of the Handicapped, as Seen on Long Island."

The findings of the study were contributed by 881 handicapped persons living on Long Island, 661 of whom were interviewed, by 336 manufacturing firms on eastern Long Island, and by 46 nonhandicapped workers in one of the industrial plants where handicapped workers were interviewed. In addition, data regarding the general population were gathered from studies conducted in three neighborhoods in which some handicapped persons of the study were living.

The setting and services of the study were:

1. *Handicapped Persons in Their Own Homes*: Nassau County Department of Health, Nursing Division; Suffolk County Department of Health, Nursing Division.

2. *Training, Retraining, Assistance with Aids and Obtaining Jobs*: Division of Vocational Rehabilitation, the University of the State of New York, the State Education Department, Nassau-Suffolk Unit.

3. *Sheltered Workshops*: Skills Unlimited, Incorporated; Brooklyn Bureau of Social Service and Children's Aid Society; Queensboro Tuberculosis and Health Association.

4. *Competitive Industry with Policy of Employing Only Handicapped Workers*: Abilities, Incorporated.

5. *Competitive Industry Employing Both Nonhandicapped and Handicapped*: Servomechanisms, Incorporated.

The data obtained included such social factors as medical history, education, training, kinds of jobs held in the past and at present, skills used, potential skills,

*Material on the Adelphi College Study with a few adaptations is drawn from the reports on the Rehabilitation Project. Detailed findings may be found in the reports. Members of the interdisciplinary team, besides the director, included Associate Director Dr. Else B. Kris (Social Psychiatry) and representatives from Economics, Education, Nursing, Psychology, Social Work, and Sociology.

conditions at work, opportunities for learning, group affiliations, and plans for the future. Included also were data regarding home and community life.

Out of the findings of the first two years, special attention in the third year was given to considering the question of why some handicapped persons had obtained jobs and others had not. Intensive follow-up interviews were conducted with 50 handicapped persons previously interviewed in the first two years of the study. The social factors previously sought were supplemented by variables of motivation and drive. Also in the third year a substudy was made of 336 firms on eastern Long Island in regard to their policies, points of view, and practices regarding the hiring of the handicapped.

Summary of Findings of the Study. More than a third of the interviewees showed primary disabilities of an orthopedic or neuromuscular nature, with postpoliomyelitis the largest subcategory. About a tenth reported their disability to be tuberculosis and seven percent had a cardiac impairment. More than a third reporting on the item of duration of handicap said they had sustained the disability more than 10 years ago.

A large number reported they were or had been married. A majority of the interviewees said they were living in households of several members other than themselves; and a few reported large households of six or more besides themselves. For the most part the interviewees were family-centered. Family cohesiveness was noted with respect to such activities as having some or all of their meals together, spending holidays together, and visiting relatives.

Most of the interviewees were born in the United States, many in New York City. In contrast, however, a large number said their parents came from other countries. Almost a fifth were living in rented apartments, and slightly less than a fifth said they lived in the parental home. Nearly a third said they owned or were buying their homes; a few of the homeowners lived in Brooklyn and Queens, but for the most part they resided in suburban Nassau County or in Suffolk County, Long Island.

Almost half said they had some or a complete high school education, and 88 had attended college for a time or had finished. A total of 166 said they had no friends; of those who replied in the affirmative, 167 said they had four to eight friends and 143 said they had more than eight. The group activities of most of the interviewees tended to be centered in the family or in the neighborhood. Membership in clubs and civic associations was minimal.

It was found that 447 were employed and 210 were not. The schedule did not include an item on income. There was a range in the type of work of the employed, with the largest number on benchwork in the plant or shop. Some were unskilled or semiskilled and others skilled. Part were in clerical work and some in service trades; a few were in semiprofessional or professional work.

Of the 50 handicapped persons selected for follow-up interviews in the third year of the study, there were 26 employed and 24 unemployed. From the standpoint of numerous social variables, a comparison of these two groups showed them to be alike in most social factors. The chief difference appeared in relation to drive and aspiration. Here many of the employed appeared to have more drive toward occupational goals than did many of the unemployed.

A considerable number reported aspirations for the future including such plans as another job, their own business, marriage (if single), and further education.

Some Special Problems. The study showed the special difficulties in finding work faced by persons with certain kinds of disabilities. Such was the case with many persons with epilepsy, others with mental retardation, and still others with remission from emotional disorders. Although many persons with such forms of disablement have found work, many are still idle. Then, too, it was noted that the worker over 50 years of age, particularly the person with multiple disability such as cardiac impairment or hemiplegia, was finding reluctance to hire him, though his disability might be well under control. Many persons held back from gainful work by such disabilities as these are able to make some adjustment in social life, but it is an adjustment that might see wider horizons and an extension of social enjoyments if there could be more chance to earn as others do.

Profiles. From the interview data, profiles were written. In the following paragraphs three vignettes have been condensed from the final report of the study:

Employed

Here is a young man 23 years of age who lost the sight of one eye in an accident in early childhood. He wears an artificial eye. He had a high school education, then obtained a job where he learned certain clerical skills. Now, several years later he is employed as a draftsman in a large engineering firm and has goals of learning further skills and obtaining work in an electrical company. Toward this end he is attending night school and would go to college if he had the money.

Positive factors in his life have included a cohesive childhood family, a marriage to a young woman with whom he feels secure, and a young son. He has taken a place as head of his own household and gets satisfaction out of having to support his family and living in a suburban community. For interests he enjoys hunting, fishing, and swimming. He also does a little magazine reading, watches television, and enjoys going to the movies. He has two or three friends and a wide circle of acquaintances. Although a little sensitive over his handicap, he has been able to cope with his feelings.

Employed

Here is a well-appearing, pleasant man aged 37, paralyzed from the waist down for the past several years. He had a limited schooling, then went to work. After several years he entered the armed forces.

After becoming paralyzed, he used a wheelchair and sought work again. Finally he found it in a workshop for the disabled. He then purchased a second-hand Cadillac and began driving to work each day, returning to his modest home at night. The first days at the shop with handicapped people upset him, but he adjusted pretty well to the setting. On the side, he has been developing some real estate interests with his brother and hopes to move to Florida later.

He had a well-knit childhood home, kept close contact with the family over the years, and now continues his pleasant relationships with his brother and sister-in-law, who live near him. His marriage having ended in divorce some time ago, he plans remarriage to a woman his age, whose companionship he enjoys. His hope is to be able one day to use crutches and lay aside his wheelchair. Meanwhile he continues at the workshop.

Unemployed

This 46-year-old man with a shortened leg and a paralyzed ankle has been unemployed for a long time. He comes of a large cohesive family circle of Italian background—the male members of which have been well set up in business. His schooling was limited. As a young man he worked as a peddler. Finally he did construction work until his accident in 1942. Through a rehabilitation agency he received some training for industrial work.

He and his wife own their suburban house in which they have lived for 25 years. His wife works gainfully in a printing shop. They have two children—a son in high school and a daughter planning to be married soon. For pastime he plays checkers with his son and pinochle with a neighbor. At the present time he does not have prospects for gainful work.

Findings from the Neighborhood Studies. In the data from the neighborhood studies, the social patterns of the handicapped were found to be quite similar to those of the nonhandicapped general population. Family rituals, interests, and values of the handicapped were seen to be much like those of the "Joneses."

*Findings from Industrial Firms.** Of the 336 manufacturing firms, a little more than a third said they hire handicapped workers. The handicapped were found to be mainly in the large firms hiring over 50 employees, and for the most part in three types of industry: manufacturing, nonelectrical; manufacturing, electrical and electronic; and home building and equipment. Although several drawbacks to hiring the handicapped were mentioned, the two most frequently reported were concern regarding need for tailoring of jobs and concern regarding accident and insurance risk. The majority of the 116 firms hiring the handicapped stated that they had found such workers to be at least average or better; 38 firms said the handicapped were among the best employees. Over two-thirds of the firms contacted indicated they had no plans to hire the handicapped.

Profiles. From the interviews conducted with executive personnel of firms, a number of profiles were written and presented in the third interim and final reports of the study. Summaries of five of the interviews follow:*

This firm manufactures electrical and electronic materials and employs several thousand workers. A good many handicapped workers are employed, including some with cardiac conditions, paraplegia, arrested tuberculosis, amputation, diabetes, and epilepsy. The experience of the firm with these employees has been favorable with respect to attendance, punctuality, production, and general attitude. The accident rate is low. The company has been active in nationwide programs to encourage employment of the handicapped.

* * *

Another firm manufacturing coats and suits employs 70 persons full time on piecework. The firm has hired handicapped workers for the past six or seven years, including two with cardiac conditions and one with an orthopedic handicap. There would be no objection to hiring a person with epilepsy if the seizures were controlled. Experience has been favorable. The executive said the handicapped worker does good work and the firm would be glad to employ more.

* * *

Still another firm that manufactures industrial plastic products has a work force of 150 to 175 employees doing mainly assembly line operations. For the past 10 years the firm has hired certain of the handicapped—including some with orthopedic disabilities. The company prohibits the hiring of persons with cardiac conditions, however, having had a bad experience when a worker with a condition died suddenly. Also prohibited, because of dangerous machines, are those with epilepsy.

* * *

A fourth firm, manufacturing goods on a subcontract basis, employs nearly 300 full-time workers in various types of machine shop and clerical work. Ten of the employees are physically handicapped, including workers with orthopedic impairments, amputation, and atrophied limbs and the blind. The executive said that in his opinion no handicapping condition is prohibitive when selective placement is done.

* * *

A fifth firm manufacturing plastic materials has 40 employees. Although the company began hiring handicapped workers in 1957, only a few have applied. In contrast to the experiences of the before-mentioned firms, this company has had an unfavorable result with those they have employed. The attendance record was poor and productivity only fair. However, the handicapped workers were punctual and there was no problem of accidents. The firm would be willing to

*Anonymity was preserved by use of code.

hire the orthopedically handicapped, but the main problem is one of facilities—workers find the stairs to the second floor prohibitive. Persons with cardiac conditions, diabetes, or epilepsy would not be employed because of fear of coma.

Conclusions from the Study. The basic assumptions set forth at the beginning of the study held true, namely that *(a)* the handicapped person is primarily a person and secondarily a handicapped person; *(b)* that work conditions and situations affect other areas of social living; *(c)* that the factor of handicap can be recognized by the individual so that he can make the most of his abilities; *(d)* that many of the handicapped persons who have obtained work show identification with the social patterns of the middle grouping in their community.

Findings of the study pointed up several outstanding needs in the field of rehabilitation including further counseling of the handicapped; increased vocational rehabilitation opportunities; further intensive work to help the homebound worker; further attention to the social role of the sheltered workshop; and increased education of the public to the potentialities of the handicapped for productive work and for living a normal social life in the community.

Present Problems and Future Needs in Rehabilitation of the Handicapped

Areas of Handicap Needing Special Help. There is no doubt that, having gotten thus far in job opportunity, the handicapped worker is likely to go farther still in the industrial world. Studies have shown that he is capable of doing the job in an average and, in many cases, better than average way and that with opportunity he can earn what others earn and can live as others live. Yet there are still many impediments to full opportunity in job and community life.

For example, there are the very *severely disabled.* Such persons are quite often homebound, living a restricted social life, having to rely entirely upon others for meeting their daily needs. Any gainful work that is possible and is provided for them at home is likely to become monotonous without the company of fellow workers to help liven the day. Actually with many at present the task is more often diversional than vocational and indeed leaves something lacking in the diversional aspect. At present, more often than not the homework does not offer opportunity for developing additional skills—with many, upgrading is minimal.

The studies presently being directed toward the problems of the homebound may point the way to finding new means of coping with the physical handicap, particularly through job tailoring. Likewise additional light may be shed on measures to encourage confidence on the part of the disabled that his work is important.

Then, too, the *mentally retarded* are in need of much additional attention. The valiant work of such organizations as the National Association for Retarded Children and of local chapters has helped to bring the young people with intellectual limitations out into open society, thus making possible new dignity of status. The workshops for disabled have opened up new areas of vocational opportunity for many such young persons formally excluded from business and industry because of retardation. A further examination of the abilities of the given person, his interests, his training needs, opportunities for training, together with an experimental attitude on the part of the employer who is willing to try hiring the limited young person—all these things lie within the realm of possibility.

Likewise there are the problems of *persons with remission from mental disorders.* In the light of modern therapies, including use of tranquilizing drugs, many former patients in mental hospitals are able to return to the community, under supportive guidance of the aftercare clinics. It has been found that many such persons seek and find their own jobs but that others are in need of counseling by vocational rehabilitation agencies. The problem of opening up opportunity at jobs is a matter of allaying the misgivings on the part of the employer and

Forthcoming

In the November issue of *Rehabilitation Literature,* the Article of the Month will be "Amputee Needs, Frustrations, and Behavior," by Sidney Fishman, Ph.D., Director, Prosthetics Education, New York University Post-Graduate Medical School, New York, N.Y.

Other articles to be featured in early issues of *Rehabilitation Literature* include "The Patient's Motor Status: Evaluation Methods and Trends," by Mary Eleanor Brown, M.A., Physical Therapist, who is Chief Research Associate of the Western Reserve University-Highland View Hospital Hand Research project at Highland View Hospital, Cleveland, Ohio, and "The Habilitation Role of the Special Educator," by Herbert Rusalem, Ph.D., who is Assistant Professor of Education and Psychology, Long Island University, and Director of Professional Training and Research, The Industrial Home for the Blind, Brooklyn, N.Y.

of encouragement of the would-be worker in order to build up his self-confidence. It is an accepted fact that many people can make a good job adjustment, even after a lengthy period of hospitalization, when they are well enough and if the working conditions are reasonably reassuring.

Again, there are real difficulties faced by another handicapped person—*the older worker,* especially the worker with a multiple disability. Despite the measures taken by some industries to erase age barriers, it still is difficult for the worker over age 50 to find ready acceptance when he applies for a job, and it is doubly difficult when he has some physical impairment such as hemiplegia. Legislation, as in New York State, to prevent denial of opportunity to the person up to 65 years of age will do something to open up chances for gainful work. More is needed, however, by way of job analysis to ascertain the types of work that the older worker with physical impairment can do if some tailoring of job is done. It is the assumption that the physically well older worker can fit into the usual kinds of job in the plant.

Many of the handicapped *unemployed,* too, having experienced rebuff in applying for jobs, have developed feelings of discouragement. There is a tendency on the part of human beings to make some adjustment to the life situation; some of the unemployed, out of despair, have accommodated to living without a gainful job. Hence motivation may be low, and aspiration may be related to unrealistic goals. Such persons need the help of supportive counseling and work opportunity.

Need for Vocational Counseling. Many handicapped people can handle matters for themselves through their own resources. But there are many others who need special counseling to aid them. For the purpose a new role has emerged—that of the rehabilitation counselor. Working in cooperation with members of the interprofessional rehabilitation team, the counselor takes into account the physical, emotional, and social needs and readiness of the rehabilitant and assists the counselee in obtaining training or retraining necessary for the job. A close working relationship is maintained with the medical profession, with psychologists, with personnel in the state employment agency, with other community personnel, and with business firms.

Training for this work includes a broad background in general subjects, orientation in the social sciences with special reference to the sociology of occupations (which considers the kinds of job available, status aspects, values of the worker, and interpersonal relationships within the work setting). Essential to the preparation also is the training in skills of interviewing gained through supervised experience in recognized field work settings.

At present the number of trained personnel in this field is far short of the needs. However, with the special training now being made available through rehabilitation counselor programs in a number of universities and colleges, there is hope for an enlarged supply of trained counselors in the future. The professional recognition of this field of rehabilitation counseling, which is presently under consideration, will do much to attract workers.

Broad Issues Involved in the Work and Social Life of the Handicapped

It has been observed that the handicapped industrial worker tends to conform to the social patterns of the general population with whom he is associated. In general, having incorporated values of the middle grouping through early orientation absorbed from his family, he tends to live as his neighbors do. As other nonhandicapped people get acquainted with him, they are seen to lose sight of the handicap and think of him as a fellow worker and community member.

With the great progress already made in employment of the handicapped, the optimum role that each of the parts in the rehabilitation continuum can play needs further consideration. As one example, an additional study is needed of the social role of the workshop for the disabled. If the workshop is to serve as a training ground for the handicapped on their way to open industry, the sequence in learning skills and the kind of other inservice education to be offered in the program and activities of the shop is a matter for further review. If the shop is also to be a place of permanent employment for the severely disabled, its role in providing optimum social working conditions and in affording status will need further evaluation.

With the present trend toward work opportunity in open industry, the handicapped worker is likely to lose his identity as such and find even closer identification with the status and values of the other workers in the plant. In his new job roles, the impaired worker will experience the same technological changes occurring in industry that the nonhandicapped does, and he is already finding that new skills are being required of him. Like his fellow worker he will have need for finding new ways of interacting profitably with others in the social system of the factory.

In home and community life, the present tendency toward a family-centered life with neighbors on the periphery is quite common among the nonhandicapped as well as the handicapped population. With the decrease in working hours and the increase of leisure time of workers, the future will probably see a new emphasis upon considering the kinds of socialization that an adult needs in relation to his family and to the community in which he plays his part. As further technological change occurs, the handicapped worker, having gained immeasurably in work opportunity, will need to move along with all the others.

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An Experiment in Mental Patient Rehabilitation

Evaluating a Social Agency Program

By Henry J. Meyer, Ph.D.
and
Edgar F. Borgatta, Ph.D.

Published by Russell Sage Foundation, 505 Park Ave., New York 22, N.Y. 1959. 114 p. tabs. $2.50.

Reviewed by Robert J. Wolff, Ph.D.

Perhaps few books give an example of solid research in an area of the behavioral sciences in just about 100 pages; this is such a book. In a precise and readable manner the authors present the problems, the research design, and the methodology used.

"Research" today is a popular word, although frequently used loosely. Many of us probably associate the word with the physical sciences or with white mice in a psychology laboratory. And it is true that only very recently have social scientists attempted to do research in the field, evaluating the effectiveness of certain manipulations such as in Meyer and Borgatta's evaluation of the effectiveness of the rehabilitation services of Altro in New York. But "research" here has a number of objectives. First, there is the evaluation of the services extended with the objectivity inherent in the use of the scientific method. Another objective could well be the collection of generalizable information, adding to our store of knowledge. And finally there is a great need to do research on how to do research!

It is tempting to speculate on why certain areas of the behavioral sciences can boast fairly rigid and concise theories based on experimental findings and others have conceptual hunches, more often than not never validated experimentally. There could hardly be a greater need to develop a theory of learning, for instance, than to develop an experimentally validated theory of psychotherapy. Nor does it seem likely that those who were interested in learning were more research-minded than psychotherapists.

About the Authors . . .

Dr. Meyer is Professor of Social Work and of Sociology at the University of Michigan, where he received his Ph.D. in 1939. He formerly was Professor of Sociology at New York University and an instructor at State College of Washington. His background includes work with the WLB as mediation officer, vice chairman of the national telephone commission, regional chairman of the WSB, and consultant in labor affairs division, High Commissioner for Germany. He has been interested and active in social welfare, industrial and general sociology, and industrial relations.

Dr. Borgatta, social psychologist, of the Russell Sage Foundation received his Ph.D. in 1952 from New York University, where he was an instructor in the Moreno Institute, 1949-1951. He was a lecturer and research associate during 1951-1954 at Harvard University and since then has been associated with the Russell Sage Foundation. In 1956 he joined New York University as professor. His fields of interest l'e in small group and group psychotherapy and personality.

About the Reviewer . . .

Dr. Wolff received his Ph.D. in 1954 from the University of Michigan, his doctorate being in social psychology. At present he is research psychologist on the staff of the Minnesota Follow-up Study, Moose Lake Hospital, on the effectiveness of predischarge planning and follow-up services for the rehabilitation of mental patients. Dr. Wolff previously worked in the field of attitudes and perceptions of the public regarding mental health and mental attitudes.

Two very important reasons why in some areas experimentation was not even attempted until fairly recently come to mind. One is cultural. Our culture imbues us with certain unquestioned values, an important value being that one does not experiment with people if this in any way might affect their health. There are exceptions, of course, and there seems to be a hierarchy of acceptability: it might be all right for a researcher to use himself as a guinea pig, in certain instances it might even be all right to use volunteer condemned prisoners, but never you or me, and certainly not unsuspecting patients. We obviously observe this cultural taboo in social science research, at the same time recognizing that this forms a restriction on what we can study and how. Occasionally a researcher tries the strength of this taboo by "using" unsuspecting subjects in ways that may not affect their health but provide them with sometimes very unpleasant experimental situations. By and large, however, we observe and share these cultural values, including the one that says that no one, not even the scientist working in the interest of science, is beyond these cultural dos and don'ts.

The second important reason why experimentation has flourished in certain areas of the behavioral sciences and not in others must be important differences in the complexity of the subject matter. An important aspect of the study of "adjustment" is we are dealing with an interaction situation, interaction between the subject and his various environments as well as interaction among his internal drives, emotions, and feelings. Until one is able to define "adjustment" as an interactional concept, it remains almost impossible to deal with a subject of such complexity! In all scientific investigation asking the right questions is of the utmost importance, a "right" question being one that can be answered. The behavioral sciences are perhaps only now beginning to ask themselves the "right" questions. We have learned only fairly recently to formulate such interactional concepts as "leadership," "cohesiveness of a group," "fulfillment of role expectations," and others. Now if we can conceive of "mental health," for instance, as an interactional concept, we may be able to ask ourselves: What pattern of factors (interacting with each other) mitigates for or against mental health?

It is undoubtedly significant that more and more social scientists devote their attention to a thorough study of some of these previously neglected areas. Despite the cultural taboos, the complexity of interactional concepts, and other difficulties, there are numerous attempts to at least collect some "facts" in the area of mental health and community adjustment, for example. Despite the fact that for many years professionals and others have worked in the helping professions, the amount of scientific observations is surprisingly small.

In the current volume *An Experiment in Mental Patient Rehabilitation* Meyer and Borgatta have added significantly to the body of knowledge concerning the returning mental patient. Although in a sense a byproduct of this study, the factor analysis of the 36 variables recorded gives us some valuable insights in recurring patterns. It is regrettable that the authors could not include a wider variety of observations. One hesitates to attach too great an importance to any of the factors because of the small size of the sample and the limited number of variables involved. Yet some of the descriptions seem so recognizably "true" that it might be profitable to replicate and expand on the measures used here.

An Experiment in Mental Patient Rehabilitation is basically a study to evaluate the services rendered to discharged patients by the Altro Health and Rehabilitation Services, Inc., in New York City, with the support of Russell Sage Foundation. The evaluation of the effectiveness of any manipulation needs criteria—but what are the criteria for success in rehabilitating returned mental patients? In the physical sciences there often is an obvious criterion, in the medical sciences there is the absence of symptoms—but in the area of mental health and mental illness there are no such unequivocal criteria. Even the most obvious criterion, readmission to a mental hospital, has been shown to be dependent not only on the "sickness" of the patient but on such other factors as the tolerance of deviance on the part of relatives, so that even hospital admission is not solely a result of how sick one is but also of how able and willing others are to tolerate odd behavior!

Even though there may not be unequivocal criteria, there are a number of signs commonly associated with mental health. In evaluating the services rendered by Altro, the authors decided to use a "control group design" comparing a sample of expatients who received the services of this agency with a control group of expatients who did not. Or, rather than ask, "Is Altro successful in rehabilitating returning mental patients?" (which would be a "wrong" question to ask, because we have no accepted criteria for success) the authors asked, "Other things being equal, do patients who receive Altro's services do better on a number of significant measures than those who do not?"

One of the valuable contributions of the book is the account of problems and solutions involved in observing that "other things are equal"! Others will undoubtedly benefit from the recording of the authors' experiences of defining and implementing a control group design. In the laboratory it is easy to administer pills to one group of white mice and not to another; it is less easy, but possible, to administer pills to one group of patients and placebos to a matched group of patients. When it comes to evaluating the difference between groups of persons who do and do not receive the services of a social agency, the administrative and professional problems increase

manifold. Meyer and Borgatta's book should be read, and read attentively, by all those engaged in evaluative field research. There is a slowly growing body of information—outstanding for instance is John and Elaine Cumming's book *Closed Ranks; An Experiment in Mental Health Education*—on the problems and pitfalls of doing research in the field.

The data collected in this study did not quite allow the authors to determine the effectiveness of services, although it appears not unlikely that failure to "prove" success may have been primarily a result of the limitations of design and measurement, rather than failure of these services to produce results.

Even though Altro may have been disappointed because the investigators could not show dramatic evidences of the success of their services to returned mental patients, the contribution to our general fund of "facts" will make it possible, later, to theorize, which indirectly will be of benefit to all social agencies. Those of us attempting to do evaluative research should be grateful for the modest and succinct record of the administrative and methodological problems faced in this study.

Other Books Reviewed

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Adapted Physical Education in Schools

By: **Ivalclare Sprow Howland,** Ed. D.

1959. 174 p. figs. Paperbound. Wm. C. Brown Co., Publishers, 135 S. Locust St., Dubuque, Iowa. $3.00.

DESIGNED FOR USE in junior or senior courses in adapted physical education, this textbook stresses ways and means by which the restricted child may participate in activities of the physical education program. Basic philosophy of the adapted program, the roles of various school personnel, parents, and school and home physicians in program planning, principles and practices in the determination of physical needs of the child, methods used in administering the orthopedic-body mechanics screening test, and the organization and administration of special classes are discussed. Chapters are included on adaptations of activities to meet the needs of children with specific disabilities, selected therapeutic exercises for the special class, and recreational activities suited to children with limited capacity. Additional aids for the student are the laboratory problems designed to give practice in organizing and operating the adapted program and the suggested references following each chapter.

762

A Comparative Study of the Self-Concepts of Crippled and Non-Crippled Children

By: **Mary Althea Krider**

1959. 280 p. tabs. Mimeo. (Dissertation for degree of Doctor of Education, Wayne State University, Detroit)

A RESEARCH PROJECT assisted by a grant from the Easter Seal Research Foundation, the study was designed to compare scientifically the self-concepts of 18 crippled children attending a school for the orthopedically handicapped with those of a comparable group of noncrippled children. Quantitative and qualitative differences in attitudes toward self and the ideal-self between the two groups of children were measured by psychological tests. Other data for the study consisted of information from school records and parental interviews. Findings of the study appeared to indicate there are no significant differences in self-concepts between crippled and noncrippled children; however, much more investigation is necessary before positive statements can be made concerning the personality of both groups. Record forms and statistical data are contained in the appendixes.

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Conquering Physical Handicaps; Official Proceedings of the First Pan-Pacific Rehabilitation Conference

By: **International Society for the Welfare of Cripples**

1959. 591 p. Published by the Australian Advisory Council for the Physically Handicapped and available in the United States from the International Society for the Welfare of Cripples, 701 First Ave., New York 17, N.Y. $3.00.

THE PAN-PACIFIC Conference on Rehabilitation, held in Sidney, Australia, in November, 1958, was the first of its kind conducted in the southwest Pacific area under the auspices of the International Society for the Welfare of Cripples. Papers presented have been condensed since the subjects covered ranged over the whole field of rehabilitation. Discussed were the philosophy of rehabilitation and community action; the management of the physically disabled child, the amputee, the paraplegic and hemiplegic, the cerebral palsied, and the arthritic and geriatric patient; special education; recreation; sheltered workshops and employment problems. Among participants from the United States were Drs. Howard A. Rusk, Henry H. Kessler, and Thomas J. Canty, also Charles Van Riper, Marjorie Fish, Jane M. Hoey, Mrs. Katherine B. Oettinger, and Margaret A. Hayes. Authorities in the field of rehabilitation in Great Britain also participated. The proceedings contain much of interest concerning rehabilitation efforts in many countries.

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An Introduction to Child Psychiatry

By: **Stella Chess**; foreword by **Lawrence B. Slobody**

1959. 254 p. Grune & Stratton, Inc., 381 Fourth Ave., New York 16, N.Y. $5.25.

DESCRIBED AS A "plainly-written, complete workbook in child psychiatry, above the level of the 'popular psychiatry' book," it emphasizes practical issues of development, personality, diagnosis, and treatment. As an easy-to-follow guide to theory and therapy, it should be of interest to all professional personnel concerned with children and their parents. With greater emphasis being placed on the psychologic aspects of pediatric practice, the physician needs background information when called upon to counsel parents. Part I relates the history of child psychiatry as a medical specialty and the development of child guidance clinics, as well as the current estimate of behavior disorders and the wide range of problems needing treatment. Part II discusses child development and the social, cultural, and environmental factors influencing it. Part III deals with diagnostic technics and procedures. Part IV offers a proposed diagnostic classification with a discussion of specific disorders, Section 13 dealing with the physiological and psychological conditions arising from such stress conditions as physical illness and handicaps, hospitalization, and learning difficulties (reading, writing, and speech disturbances). Part V is a guide to the general principles of therapy, the use of drugs in treatment, and the specific application of various therapies.

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Papers Read at the Conference of Social Workers on the Rehabilitation of the Crippled, Pretoria, June, 1958

By: **National Council for the Care of Cripples in South Africa**

1959. various paging. Paperbound. Mimeo. National Council for the Care of Cripples in South Africa, P.O. Box 10173, Johannesburg, S. Africa. 6/6 post free.

TWENTY-ONE PAPERS presented at the Conference organized by the Council in 1958 are included; six are in the Afrikaans language, the remainder in English. Collectively the lectures stressed the need for orienting social workers toward medical social work, both in work with the handicapped and in other specific medical fields. Subjects covered general discussions of orthopedic disabilities and their treatment; the various roles of ancillary personnel such as the occupational and physical therapists, the after-care nurse in orthopedics, and the social worker; the purpose of orthopedic appliances; organization of the rehabilitation center; vocational training; and employment problems in placement. (See #768 this issue of *Rehab. Lit.*)

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Principles of Disability Evaluation

By: **Wilmer Cauthorn Smith, M.D.**

1959. 210 p. figs. J. B. Lippincott Co., E. Washington Sq., Philadelphia 5, Pa. $7.00.

USING THE Oregon Workmen's Compensation Act as a frame of reference, the author discusses the concept of disability compensation and the increasing responsibility of the physician in this field. The second section of the book defines and elaborates on the concept of medically ratable industrial disability and considers the basic relationship between the workman and industrial employment, as applied to disability compensation. Section 3 examines the etiologic relationship between injury and disability or disease. Principles underlying a sound medical approach to disability determination are presented. In Section 4, actual evaluation in specific conditions for varying degrees of disability is discussed from the standpoint of the concepts and principles that must underlie a rational approach to appraisal. Because of the scarcity of literature in this area and the inconsistencies existing in legislation and evaluation of disability, the physician will find much of practical value here. Also discussed at length are the composing of medical reports, delivering medical testimony, and the mechanics of evaluating partial and total disability.

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Proceedings of the Second World Congress of the Deaf, Zagreb (Yugoslavia), August 23-27, 1955

Edited by: **Maslic Ferdinand** (and others)

1959. 433 p. illus. Central Committee of the Yugoslav Federation of the Deaf, Marsala Tita 6/1, Belgrade, Yugoslavia. $5.00.

DELEGATES FROM 34 countries participated in the Second World Congress of the Deaf, reporting on the current status of rehabilitation efforts for the deaf in their respective countries. The proceedings contain reports on the work of the World Federation of the Deaf from 1951 to 1955; a great number of papers concerned with the medical, educational, social, and vocational aspects of rehabilitation of the deaf, many of which are technical in nature; and a discussion of the possible unification of sign language on a worldwide basis.

A preliminary booklet *Problems of the Deaf in the World; Informative Review* was prepared and distributed in 1955 to provide background information on the agenda (see *Rehab. Lit.*, Jan., 1956, #29).

Digests of the Month

Journal articles, chapters of books, research reports, and other current publications have been selected for digest in this section because of their significance and possible interest to readers in the various professional disciplines. Authors' and publishers' addresses are given when available for the convenience of the reader should he desire to obtain the complete article or publication. The editor will be most receptive to suggestions as to new publications warranting this special attention in Digests of the Month.

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Practical Aspects of Placing the Non-European Cripple in Employment

By: **Mrs. M. P. du Plessis** *(Welfare Officer, Johannesburg City Council, Non-European Affairs Department)*

In: *Papers Read at the Conference of Social Workers on the Rehabilitation of the Crippled, Pretoria, June, 1958.* 1959. Various paging. Mimeo. National Council for the Care of Cripples in South Africa, Johannesburg, P.O. Box 10173, Union of South Africa. 6/6 post free.

I have always been painfully aware of the haphazard, uncoordinated, amateur efforts used in placement of Natives. We let them down—usually not because of fault of the Social Worker but because of lack of the machinery, organisation, and specially trained personnel. What services we have are practically unavailable to the Non-European. Baragwanath Non-European Hosptial near Johannesburg has an excellent medical unit for paraplegics, but their employment after discharge is still unsolved. I am speaking on a subject not my specialty at all, simply because there is no one else to fill the bill. Usually the placement officer for Non-Europeans is the harrassed Social Worker who cannot keep up with her work as it is and who has no specialised knowledge for the job.

The Non-European field is vast. The incidence of deformities caused by tuberculosis is very high. Congenital deformities are much commoner than in Europeans since they so often are not reported and treated in infancy. Paralysis, usually severe, resulting from stab wounds inflicted by "Tsotsis" and similar criminal elements is becoming more prevalent. Such stabbings occur every day, frequently to law-abiding citizens, often in pay-day robberies. Non-European hospitals on the Rand have wards full of paraplegic patients, who are impossible to place in employment. Only the fringes of the problem of employment for the Non-European homebound have been touched.

A free artifical limb cannot be obtained from the Government Social Welfare Department without a guarantee of employment when it is supplied. How can one look for a job without a prosthesis one knows how to use? The number of Natives who can pay for appliances is negligible.

The greatest demand for Native labour is in manual work unsuitable for a cripple. Most disabled Natives are not sufficiently educated for clerical jobs and, in any event, there are always more able-bodied educated Natives than there are clerical posts to fill. Employers tend to regard all Natives as menials, to fetch and carry, as "hewers of wood and drawers of water," or as sweepers or labourers. There are no definite limits to a Non-European's job. A disabled man employed as a cobbler was not satisfactory to his employer although he was good at cobbling because he could not sweep out the shop and run errands. One occupation frequently reserved for the disabled is as a lift man. In buildings occupied by Europeans fewer and fewer Non-Europeans are employed. Non-Europeans will continue to be used in goods lifts, but many disabled cannot handle heavy goods.

Apathy. Many Non-European cripples have sunk into a deep rut of apathy, partly due to the effects of crippling disease or disabling accident and the resultant life. This is also found in many able-bodied Natives and is in part due to their socioeconomic background. Malnutrition may be one of the largest contributory factors. This apathy or resistance to employment is particularly marked in those who have never worked or have not for a long time. Without a rehabilitation centre or industrial training centre where cripples may be "geared up," there is little hope of successful placement. It is much easier for a Native cripple to become a beggar than for a European. There is no social stigma and there is not always an easy alternative. A very badly disabled Native cannot be placed in the open labour market, and sheltered employment for Non-Europeans is almost nonexistent. The invalidity grant for Natives is totally inadequate and quite unrealistic viewed against an urban background and the current cost of living.

Transport. The present trend (here I speak mainly of the reef towns) is to site the Native townships further and further away from industrial and commercial areas. In many cases going to work consists of a train trip, a bus ride, and a walk. Traveling by Non-European train, and again I speak of the Rand, requires fitness and stamina for the able-bodied. It is beyond the endurance of most slightly disabled. It entails standing in queues for long periods, coping with the stampede for seats, and being tightly packed in carriages. There is always the possibility of the unwelcome attention of the Tsotsis. Europeans may get lifts and sometimes use public transport, but this is hardly the case for Natives. Most Non-European cars are unofficial hired taxis and carry double

the correct load. Non-Europeans must live close to a place of employment but are confined to certain residential areas. In urban townships they must be registered as tenants or subtenants. Most Township Superintendents are sympathetic to applications by cripples, but relatives often will not take them in unless they can help substantially with household expenses.

"ANY PRESENTATION and evaluation of the true worth and development of the field services carried on in the Union of South Africa must be set against the background of the unique and difficult circumstances which prevail in the country, and its somewhat chequered history. South Africa is a young and growing country—growing amidst the storms and stresses of divergent outlooks and conflicting aspirations. The Union as an established political entity is not quite fifty years old. Superimposed upon its relative youth are the immense complications of a multiracial society with which it has to grapple, rendering every problem and situation abnormally involved and intricate. It has, therefore, not had the freedom to give to the more humanitarian problems the attention and care that older communities have bestowed. Welfare services upon a nationally organised basis only go back some twenty or thirty years. A very large proportion of the population still lives under primitive conditions and remains uneducated and unenlightened. The tremendous industrial expansion that followed the last war has induced a progressive shifting of the rural population for all races from the country to the towns, and has brought in its wake social problems of an unusually complicated and stubborn character. The multiracial composition of the population—European, Coloured, Indian, and African, bringing with it a wide diversity of language, cultural and educational standards, religious and ethical concepts and beliefs—magnifies the problems confronting all welfare organisations in devising good and adequate field services."—*From "Field Services for the Care of Cripples in South Africa," by J. C. Merkin, Esq., p. 384, in* Conquering Physical Handicaps; Official Proceedings of the First Pan-Pacific Rehabilitation Conference, Held in Sydney, Australia, Nov. 10-14, 1958. *1959. 591 p. International Society for the Welfare of Cripples, 701 First Ave., New York 17, N.Y. $3.00.*

Influx Control Legislation. The larger towns, Johannesburg in particular, appear to be a mecca for the disabled. Some cripples come up to Johannesburg for treatment and remain illegally. A social worker or placement officer should check to make sure the Native's reference book is up to date and bears the needed legend "permitted to seek work in the urban area of . . ." Influx control is being rigidly applied.

Placement. The placement of Non-European cripples has not been attacked in as comprehensive, scientific, or methodical a manner as desirable and possible. A start has been made at the Cape, where a Rehabilitation Committee has appointed a placement officer, although only for Coloured cripples. As far as I know, there is none in the Transvaal. Social workers and sometimes the Employment Bureaux attached to registration offices place Non-European cripples. Generally the Social Worker is so busy she refers the cripple to one of the few employers who in the past has been persuaded to accept a cripple or two. The case load for Non-European welfare work is usually higher than for Europeans. The Employment Officer supplying labour as a rule has not the time or the special interest of the disabled worker at heart to truly serve the disabled.

Placements must be planned. The placement officer must go out into the commercial and industrial world and spot jobs that are suitable. He then must persuade the employer that the disabled can do the work satisfactorily and gain the employer's cooperation to the point where he will reserve such jobs for the disabled only. The crippled person must be prepared for the rigours of competition with the able-bodied. If he has never worked or has not since being injured, considerable preparation is needed.

Follow-up services are seldom done for the Non-Europeans. Minor difficulties at work that could easily be cleared up by a placement officer mean lost jobs. Twofold harm can be done; it decreases a worker's confidence and causes resistance to further job-hunting and it minimises the chances of the employer accepting other cripples.

Employers cannot be expected to be philanthropists. If there is doubt about the cripple's ability, it could be suggested that the cripple work without pay for a short probationary period. If satisfactory, he could be given his back pay. Many workers would be glad to be able to prove their worth. Local welfare associations might agree to make up the back pay or part of it when there is failure.

Despite general prejudice, some sympathetic employers hire the crippled wherever possible. The satisfied employer is the best publicity. A great many factory jobs exist, especially in light industry, on assembly lines, and in electrical business, where the crippled could be employed if he could travel to and from the place of employment, but there must be concerted action from commerce and industry and from a representative of cripples such as a placement officer. The approach and drive would have to come from the side representing the cripples. The employment of placement officers is highly desirable.

You, however, are social workers. The Social Worker must work out her own campaigns and plan strategy according to means at hand. She has to cultivate employers. It is important to stress positive attributes of the cripple, what he can do, not what he cannot. It is necessary to get a complete history to ascertain any previous employment and to find out and make use of any residual skills. Those

Natives who have been unemployed for some time will probably have clothes that bear testimony. Employers are not impressed or moved to pity by rags, especially dirty rags. If it is possible to build up a clothes cupboard of a few presentable clothes, do so, so that the work-seeker may have some feeling of confidence. The reference book should be in order. Check whether exemption from taxes for medical reasons has expired, for the taxes would have to be paid upon getting a job.

The reward is great when one sees a man who had thought he might never work again and who feared for the welfare of his family placed in congenial employment and able to hold his head high.

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The Practical Nurse in a Rural County

By: **Section of Public Health Nursing, Minnesota Department of Health** *(Minneapolis 14, Minn.)*

August, 1953. 13 p. Mimeo.

Today it is generally agreed that home nursing care and rehabilitative nursing services should be available to people in rural areas just as it is in large urban centers. But providing adequate services presents a problem. Some public health nurses have found it hard to balance demands for nursing care and that for traditional services. This report deals with changes made in the activities of a rural one-nurse county public health nursing service when a licensed practical nurse was added to help with home nursing care services. It was thought many counties in Minnesota might benefit from the experiences.

Background

Rather than the recommended ratio of one public health nurse for each 5,000 population, most public health nurses in out-state Minnesota serve about 16,000 people, and some as many as 30,000. The state's 87 counties are covered by 8 district health offices of the Minnesota Department of Health, which provide consultation and supervision for local public health nurses but do not serve patients directly. All the county public health nursing services offer a generalized public health nursing program including school health services. Most rural counties employ only one public health nurse despite ever-increasing demands. Legislation in 1955 enabled counties with public health nurses to employ licensed practical nurses to extend home care services and to establish fee systems for care on the basis of visit costs and ability to pay. No fee is charged for health counseling visits where no nursing care is rendered.

The Study Setting

Steele County, 425 square miles in area, has a population of 21,155 (1950 census), the county seat Owatonna having 10,191 persons. Its nursing service is typical of those in rural areas, with one public health nurse and a full-time secretary. No other generalized nursing services are available. Owatonna has a school nurse for school-age children only. The county service has responsibilities relating to parent classes, immunization and crippled children's clinics, and school health services in addition to home visits for health counseling and nursing care. The agency periodically gives field instruction for a university accredited for preparation in public health nursing.

> "TO MEET its responsibilities for the chronically ill, . . . the public health profession must unequivocally reject the 1:5,000 ratio as the goal for public health nursing personnel. This ratio is obsolete, unrealistic, and a serious block to the rapid growth in public health nursing which is urgently required. . . .
>
> "Not only must we triple the number of public health nurses, but their services must be supplemented to satisfy the need for comprehensive home care programs. Such programs, established by the local health department to serve the entire community, will provide the physician with all necessary services and equipment to enable him to give adequate care to chronically ill patients for whom home care is feasible. These include, in addition to various types of nursing care, such services as physical and occupational therapy, medical social work, x-ray and laboratory service, housekeeper service, transportation, sickroom equipment, supplies and appliances."—*From "The Changing Face of Public Health," by Milton Terris, M.D., p. 1115, in* Am. J. Public Health, *Sept., 1959.*

General Procedures

Funds for the project became available in 1957 through Public Health Service monies granted to extend or develop community services for the chronically ill. The licensed practical nurse began work March 1, 1958. Various orientation experiences were provided for both nurses.

The usual policies of offering home nursing care services on a visit basis were followed. Patients were under medical supervision and written orders were required for treatments and medication. The public health nurse made first visits to each patient; subsequent visits by the licensed practical nurse were planned on the basis of total nursing needs. The public health nurse made periodic visits for necessary care and to assay progress and needs and retained responsibility. The practical nurse's duties were limited and related to nursing care—bathing, general personal care, bed positioning, range of motion exercises, enemas, simple wound irrigations and dressings, certain hypodermic injections, and assistance with getting out of bed and walking.

Types of Data and Collecting Instruments

Data were collected from family folders and individual

patient records; daily and monthly routine statistical and narrative reports; time study forms; activity of daily living checksheets; daily mileage forms for location of patients and distances covered; records of the judgments of the public health nurse on the project's assets and its impact on her job.

Findings and Conclusions

Findings indicated that adding a practical nurse to the staff of a one-nurse rural agency significantly increases the availability of home nursing care services without reducing the performance of other customary services. Therapeutic nursing visits increased 472 percent, and all types of visits made increased 199 percent. (See table 1.) Adult admissions increased 108 percent and admissions to all classifications of service 13 percent. Admissions of preschool children increased 100 percent. In 1957, exclusive of visits for maternity cases, tuberculosis, and acute communicable disease, 12 adult patients were visited an average of 6+ visits; in 1958 an average of 14+ visits were made to 25 such patients. In 1957 the public health nurse averaged 48 visits per month; in 1958 she averaged 50 and the practical nurse 80, a total of 130. Mileage increased by 101 percent.

TABLE 1.—*A Comparison of Patient Admissions and Patient Contacts by Program and by Service Rendered (April, May, June, July of 1957 and 1958)*

Program	Total Admissions		Total Visits		Therapeutic Nursing Visits		Health Counseling Visits	
	1957	1958	1957	1958	1957	1958	1957	1958
Communicable Disease	0	1	0	4	0	3	0	1
Tuberculosis	4	1	6	23	2	13	4	10
Maternity	8	4	27	7	1	2	26	5
Infant	11	9	23	32	2	20	21	12
Preschool	7	14	7	60	0	5	7	55
School	8	8	26	16	5	7	21	9
Adult	12	25	77	374	46	282	31	92
Cancer	2	1	22	6	7	6	15	0
Heart	1	1	5	19	4	8	1	11
Other	9	23	50	349	35	268	15	81
Crippled Children	9	4	9	7	2	0	7	7
Rheumatic fever	4	0	4	0	2	0	2	0
Other	5	4	10	7	5	0	5	7
Totals	59	66	175	523	58	332	117	191

Time study data on one week of the public health nurse's time in 1957 and 1958 and the nurse's judgment of her activities over comparable four month periods in each year indicated that agency functions aside from visiting were maintained in essentially the same manner. During the experimental period, with considerably less than twice the amount spent, three times as many visits were made to patients. (See table 2.) The cost per visit dropped from $4.62 to $4.00, since the licensed practical nurse's cost per visit was $3.66 and she averaged 1.53 times as many visits as the public health nurse. Greater benefits per dollar invested were obtained since nearly three times as many visits were completed while agency expense was considerably less than doubled and the per visit cost reduced 13 percent.

TABLE 2.—*Agency Visits and Expenses for Four Months of 1957 (PHN only) Compared with Same Period in 1958 (PHN and LPN)*

	1957	1958	Percentage Increase
Total Patient Visits	175	523	199%
PHN Expenses	$2,560.35	$2,560.35*	
LPN Expenses	00.00	1,377.28	
Total Expenses	$2,560.35	$3,937.63	53%

*Excluding salary increase for PHN in 1958 to allow appropriate comparison

PHN = Public health nurse LPN = Licensed practical nurse

The public health nurse felt that pressure and urgency were relieved by the help of a practical nurse, resulting in better planning, earlier visiting, and more time for working with patients and families in motivation and self-help. More frequent visits could be made and there were more new contacts. The public health nurse noted definite improvement in the health counseling she was able to give. She had more time for thorough nursing care and for work with tuberculous patients. Mothers developed more interest and motivation. Quicker follow-through of referrals from physicians, teachers, families, and others was possible.

Based on a case study analysis of a hemiplegic patient whose progress before and during home nursing care was recorded, it was concluded that establishing skills and habits that contribute to increased independence of living can be instituted and maintained with desirable results. Nursing skills offered by a licensed practical nurse can effectively complement the services normally offered by a one-nurse, county public health nursing agency.

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Clothing Needs of Physically Handicapped Homemakers

By: **Clarice L. Scott** *(Clothing and Housing Research Div., Agricultural Research Serv., U.S. Dept. of Agriculture, Washington 25, D.C.)*

In: *J. Home Econ.* Oct., 1959. 51:8:709-713.

The problem of clothing needs suited to physical handicaps affects about 10 million homemakers. The clothing and housing research division of the Institute of Home Economics has initiated a study to develop functional clothing to meet the everyday needs of homemakers with ambulatory handicaps.

A pretested questionnaire was used in interviewing 70 homemakers, 21 to 82 years old, of metropolitan Wash-

ington, whose handicaps resulted from infantile paralysis, multiple sclerosis, arthritis, muscular dystrophy, accidents, and amputations. Most women used an aid—wheel chair, crutches, braces, walker, or cane. Often shoulder, arms, and hands, as well as the lower body, were involved. Over one-third had 1 to 4 children at home, ranging in age from 7 months to 17 years. Forty homemakers lived in houses, 30 in apartments. All but seven did their housework, with some family help.

The most trouble with clothing was had by those who had infantile paralysis, multiple sclerosis, and arthritis or who used wheel chair, crutches, or braces. All arthritics and many with multiple sclerosis used dresses for housewear; when hands are involved in the handicap, dresses are easier to manage than skirts and slacks. Those with braces preferred separates, as skirts and slacks are of tougher materials and separates are more easily replaced when damaged. Most regarded aprons as essential, for added protection from spilling, for working with foods in their laps, and because they are easier to wash and iron. Slips were used by almost all who wore dresses or skirts, but there is a trend toward buying heavier garments to eliminate use of slips. A jacket or sweater was worn indoors for warmth by practically all, especially by the arthritics and those with multiple sclerosis. Age may have influenced this, for the arthritic group averaged about 57 years, while the infantile paralysis group, who used sweaters least, averaged about 36 years.

Skirts. The almost unanimous skirt preference was the moderately full. The favorite width is 2 to 2½ yards. Too full skirts are heavy, drag with sitting, catch under crutches with rising, and interfere with a wheel chair. They are harder to "do up." A closer fitting skirt is harder to get on and off and does not adjust with movement. A moderately full skirt covers the knees when one is sitting, does not work up, and does not have "lap puff." It is safer than a slim skirt in walking with crutches or brace and more convenient for managing stairs, entering or leaving a car, and at the toilet. Stout women preferred flared or four-gore skirts and fullness grouped at side front and back. Those in wheel chairs preferred gathered or pleated skirts for ease in sliding to another seat, since straight seams are sturdier than the bias seams of flared skirts. Those who had used wrap-around skirts liked them, preferring the lapping in back because of spreading apart. They are easy to put on and a slip is not needed. Those in wheel chairs do not have to rise to pull the skirt down. Wrap-arounds are convenient at the toilet.

Blouses. Those who work from a chair strain garments in reaching. Better than one-piece garments, separate blouses nevertheless split, tear, and rip. Tails of ready-made blouses are too short for most. Women with extreme curvatures like blouses and skirts because they adjust to their figures.

Sleeves. Set-in sleeves are most commonly available and bought. Their high underarm cut is preferred by women with underarm crutches, as damage in this area is a problem. Women who had worn kimono sleeves liked the ease given in dressing, the freedom and comfort, and their adaptability to irregular shoulders. They do not cling to moist skin. (Most handicapped women perspire more than the able-bodied.) However, kimono sleeves split when not cut right and some thought they looked sloppy.

For hot weather, sleeveless garments were liked. Arthritics, who prefer warmth, and those with crutches used them least; underarm crutches catch in the armholes. Few liked long sleeves. Almost all liked sleeves above the elbow and out of the way of dishwater, etc. A small number liked three-quarter sleeves that may be pushed up, but only for winter.

Action features. Very few looked for action features such as pleats, gathers, and bias cut when choosing clothing. Several had such garments and liked them without realizing why. Blouses most frequently need "give" in the back. Front give was wanted by some troubled by buttons pulling out of vertically cut buttonholes with backward movements used in operating a wheel chair or using crutches.

Necklines. The open V style with collar was liked by all. Some preferred a low rolling collar that will not ride up at the back when they operate a wheel chair or walk with crutches. Low colllars feel better and look neater. Many liked collarless dresses for hot weather, although the dress tends to gap in front with forward leaning to operate a wheel chair or walk with crutches. A high neckline gave several a feeling of "choking" or "crowding." A few who wanted this type had shoulder involvement, which makes open-necked dresses shift. Those with multiple sclerosis desired low necklines enabling them to see to manipulate fastenings.

Dress openings. Dress openings were wanted in front rather than the side. Four of the six groups preferred the three-quarter length openings, as with full-length dress openings lower buttons rip off, buttonholes tear, and fabric becomes damaged, and because there is "not as much buttoning" compared to the longer opening. The placket is long enough so the dress can be put on easily over the head or feet. Crutch users liked both the three-quarter and full-length openings, while the latter and surplice openings appealed to brace wearers. Although there are more buttons, full-length-opening dresses are easily managed when dresses cannot be lifted over the head and balance is a problem. However, if hands are involved the full-length opening has too many fastenings. Only a few favored the front-lap surplice opening, as dresses spread apart and a free hand is required to keep

them closed. Zipper fastenings were liked if they work.

Fastenings. Smooth round buttons with a rim for aid in grasping were best liked. Buttonholes should be long enough to slip over buttons easily but not so long that they pull out with strain. Few had used the new mechanically attached snap fastenings; those with arthritis or multiple sclerosis anticipated difficulty. The few who had used wrap-arounds preferred front ties.

Pockets. Large skirt pockets were wanted to hold numerous personal items, for working aids when cleaning, and for cooking items. The ordinary blouse pocket was not liked by the majority. With bending, things spill out and for some a breast pocket is hard to use. The ordinary blouse pocket was used only for a handkerchief.

Slacks and shorts. Most women desire slacks and shorts because of the coverage when getting in and out of cars or being carried, because they are not in the way of crutches, and because they are of sturdy material. When well cut they are ideal for exercising. Shorts are cool in summer and slacks warm in winter. However, dressing is difficult. For women with hand involvement, a separate belt run through loops, the waist fastening, and side zipper are difficult. (A skirt may be zipped in front and slid around to the side.) Those with braces do not like the present styling of slacks—with tapered, close-fitting legs. Women who sit much of the time say available slack bind through the crotch and over the thighs and strain against the knees.

Aprons. The women are still looking for the ideal apron. Some when working seated used newspapers instead (they get soggy and the ink runs) or a sheet of plastic and a towel (plastic slides). Bib aprons are needed but are made too long in both bib and straps. Modification is needed for those unable to lift straps or halter overhead. Makeshifts tied around the neck are humiliating and indicate the need for a functional apron. Sturdy work aprons are needed, with handy pockets for holding aids. Aprons should not pull off with the weight of things in pockets.

Slips. Many questioned the need for slips. They are difficult to put on and off, get in the way in the toilet, and are "something to take care of." Heavier dresses are favored. The dress-length pullover slip was most used. Some would like a front opening. Half-slips had been tried, to do away with sliding shoulder straps, but pull down and show in back. A few were satisfied with slips with built-up shoulders. The favorite material, nylon tricot, is slippery and has stretch, which aids in dressing, is easy to wash, requires little or no ironing, and is durable. However, it is warm in summer and has static electricity in winter, clinging and interfering hazardously with brace latches. Cotton slips have summer comfort but are bulky and cling, especially to other cottons, and good quality ready-mades, are hard to find. Lace trim catches on braces.

Indoor wraps. The knitted cardigan was most used, because of its ease in donning and its comfortable "give." Few had used shrugs. They were harder to put on. Orlon was preferred and wool less liked because of the care involved. Cotton appealed to those who perspire, but types tricot, is slippery and has stretch, which aids in dressing, requiring little care were specified.

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Workmen's Compensation at the Crossroads (President's Address)

By: **Elmer H. Kennedy,** Supervisor *(Rehabilitation Center, Washington Dept. of Labor and Industries, Seattle)*

In: *Workmen's Compensation Problems, Proceedings of the 1958 Convention of the International Association of Industrial Accident Boards and Commissions, Seattle, Wash. (U.S. Dept. of Labor Bul. 201).* Washington, D.C., 1959. Available from Supt. of Documents, Govt. Print. Off., Washington 25, D.C. 60¢.

We in the state of Washington have been successful in keeping our law reasonably abreast of current conditions, but, because of our pioneering start, we are beset by outmoded provisions. The fundamentals of our law, unchanged since its passage 47 years ago, are more comparable to the Canadian system of workmen's compensation than the laws of any other state, except possibly Oregon and Ohio. Our original medical aid provisions were so broad that we did not have to change the basic law one iota to set up a complete and integrated rehabilitation program, including a new one-million-dollar rehabilitation center. As your former Rehabilitation Committee Chairman, I like to emphasize that the end result that helps most in any rehabilitation program is placing the injured worker in a suitable job where he can meet his responsibilities to himself, his family, and his community. The injured worker who has a job to go to gets well—the injured worker without a job to go to cannot afford to get well. It might be better if we renamed our rehabilitation centers for injured workers "Physical Restoration and Placement Centers" in an attempt to "keep our eye on the ball" and emphasize their true purpose. It is my obligation and privilege today to direct your attention to current problems in workmen's compensation.

Second-Injury Funds

Second-injury funds, a part of workmen's compensation since the 1920's, increased rapidly in the 1940's,

emotionally stimulated by the desire to assist one-armed or one-legged war veterans obtain employment. In 33 states if a person already partially dismembered loses another member, causing total disability, the difference in cost between the member lost and the total disability pension is borne by the second-injury fund. Five states have no second-injury funds; five have "broad coverage" funds covering anything that ails the worker before the claim *but only total disability* as a basis for a second-injury claim. Only five states have "complete coverage" second-injury funds, covering not only any ailment making the results of the industrial injury worse but also to some extent any prolonged temporary or permanent partial disability resulting from the combined conditions.

This brief analysis of second-injury funds shows clearly that in all but five states they are but a gesture covering only part of 1 percent of the preexisting conditions that are forced upon our workmen's compensation systems for economic relief since there is no general health and welfare program for the aging injured worker. Born of emotion, our second-injury funds are only a pretext to relieve our conscience. If they are to save the insurance principle of workmen's compensation, they must cover all preexisting conditions and all major degrees of temporary or permanent partial disability, as well as total permanent disability resulting from both a preexisting condition and an industrial injury. Otherwise an employer of the handicapped is forced to assume all the financial burden, except in a few states where the cost is shared by the second-injury fund. No wonder employers can give only nominal or "lip-service" to the employ-the-handicapped campaigns!

Second-injury funds are financed on some "catch as catch can" basis by all industry covered by workmen's compensation laws. However, society as a whole is responsible for preexisting conditions that create need for these funds. Proof of this is the fact that, if the claim is not allowed under workmen's compensation laws, the claimant often is entitled to welfare medical care and subsistence payments or federal vocational rehabilitation services. Legislation should be secured to finance second-injury funds jointly from general tax funds and workmen's compensation insurance premiums. An entirely new "Pandora's box" of administrative problems may be opened, but it would help keep the bookkeeping straight. Instead of the need for a health and welfare program destroying the workmen's compensation fund, workmen's compensation could thus be in a position to handle the phases of a health and welfare program that threaten the continued existence of workmen's compensation on an insurance principle.

However, I am not saying that Jonah should turn the tables and swallow the "welfare" whale; I am saying only that we should devise a legalistic defense to keep the welfare whale from destroying workmen's compensation on an insurance principle. The well-meaning and humanitarian doctors and courts now imposing this burden on workmen's compensation are not knowingly desirous of destroying workmen's compensation—they have no recourse other than to give the injured worker the benefit of the doubt and assure him of medical care and subsistence.

This dual concept of broadening both coverage and sources of funds for second-injury funds might also have a very far-reaching effect on award schedules, which are totally unrealistic in relationship to living costs. Borderline cases have created a great financial burden for industries covered by workmen's compensation laws and resulting resentment has led to strong resistance to adequate award schedule increases. Actual impoverishment results for the worker who suffers a bona fide and serious injury in the prime of life and earning power. Relieving industry of some of the burden of these preexisting and borderline cases may well reduce industry's resistance to much needed increases in award schedules.

Occupational Disease Laws

Present occupational disease laws are even more inadequate than are our second-injury laws and our inadequate award schedules. The atomic age in industry with its use of radioactive materials is not just approaching—we are in it! We are not prepared for the new responsibilities and problems. This Association has long been state's rights oriented, but whether legislative action can be taken in time by the individual states' processes is one that must be left to your judgment and conscience. The final decision will rest with Congress, but we have a responsibility to make sound, realistic, and constructive recommendations.

English System

While the English program of workmen's compensation (it has merged with the general health and welfare program) provides only subsistence at slightly higher rates than the general welfare program, it has the added incentive of permitting the injured worker to collect this sure and certain subsistence and *in addition* sue his employer, with common law defenses removed, if negligence can be proved. As a social principle this is not compatible with our concept of industrial insurance as a program for *complete* economic protection (at least 67% of wages) of the injured worker and his dependents that goes automatically into effect when an accident occurs. Nor is it compatible with the humane principles of capital and labor relations we had hoped were replacing the barbaric concepts inherited from the 18th century English Industrial Revolution. However, national associations of attorneys will find a ready audience for their hopes to adopt the English system in the United States. Labor

(Continued on page 318)

This abstracting section, together with other numbered references indexed in this issue, serves as a supplement to the reference book Rehabilitation Literature 1950-1955, *compiled by Graham and Mullen and published in 1956 by the Blakiston Division of McGraw-Hill Book Company, New York. An author index will be found on the last page of the issue.*

ARCHITECTURE (DOMESTIC)—DESIGNS AND PLANS

772. Paralyzed Veterans of America

Wheelchair houses. New York, Paralyzed Veterans of America, 1959. 16 p. illus., floor plans.

Although the plans of the eight houses included in this booklet are not intended to serve as blueprints, they can be used as guides for designing homes for wheel chair living. Floor plans and front elevations are pictured, as well as plans and specifications for three different types of home elevators, designed to transport a wheel chair and occupant one flight up or down. Economical in construction, the elevators can be built by carpenters, builders, or machinists. Reprinted from *Paraplegia News.*

Available free of charge to any paraplegic, civilian or veteran, from *Paraplegia News,* 240 Lee Ave., Stroudsburg, Pa.

ARTHRITIS—EMPLOYMENT

773. Goldman, Rose *(400 First Ave., New York 10, N.Y.)*

Finding jobs for arthritis patients. *J. Rehab.* May-June, 1959. 35:3:21-23, 26-27.

The New York Arthritis and Rheumatism Foundation and the Institute for the Crippled and Disabled, New York City, sponsor a "Back to Work" program for unemployed persons with moderate to severe arthritis. Placement technics used to secure employment for such clients are described; they are equally applicable to any program of intensive selective placement of the physically handicapped.

AUDIOMETRIC TESTS

774. Hardy, Janet B. *(Baltimore City Health Dept., Baltimore 2, Md.)*

Hearing responses and audiologic screening in infants, by Janet B. Hardy, Anne Dougherty, and William G. Hardy. *J. Pediatrics.* Sept., 1959. 55:3:382-390.

In same issue: Two symptoms pathognomonic for congenital central communication disorders in children, Henry J. Mark. p. 391-396.

Describes auditory screening technics developed and tested in a pilot study in two child health clinics of the Eastern Health District, Baltimore City Health Department. Infants tested were placed in one of three groups —the newborn, those from 3 to 30 weeks, and those over 30 weeks of age. A simple "clacker" test was used with newborn infants: it appears to be simple and practical and could easily be incorporated in the general pediatric neurologic examination. The test method used with infants in the second group requires a moderate amount of skill and experience on the part of the examiner. Useful as a diagnostic and research tool, it is probably not applicable as a screening device on the general pediatric and public health level. Methods devised by Dr. and Mrs. Ewing of Manchester, England, were used to test those over 30 weeks of age and appear to constitute a simple screening device useful in the clinic setting. It can be carried out by nurses with a modicum of special training.

The paper by Dr. Mark *(Diagnostic and Evaluation Center for Handicapped Children, 709 Rutland Ave., Baltimore 5, Md.)* describes two symptoms common among children with central communication disorders. He suggests that failure to make expected responses to sound, irrespective of intensity level, and total absence of consistent vocalization with communicative intent in children old enough to have speech call for an expert evaluation at the earliest possible time. Methods used for identifying the symptoms during routine pediatric examinations are discussed.

BLIND

775. Parmelee, Arthur H., Jr. *(Dept. of Pediatrics, Univ. of California, Los Angeles 24, Calif.)*

The development of 10 children with blindness as a result of retrolental fibroplasia; a four-year longitudinal study, by Arthur H. Parmelee, Jr., Claude E. Fiske, and Rogers H. Wright. *A.M.A.J. Diseases of Children.* Aug., 1959. 98:2:198-220.

A report of a four-year follow-up study of 10 prematurely born children blind as a result of retrolental fibroplasia. When tested during the first year of life by means of the Gesell Infant Development Test, all were considered developmentally normal although one child had a severe hearing deficiency. (For annotation of this earlier report, see *Bul. on Current Lit.,* Oct., 1955, #1041.) Detailed biographic summaries of the children's mental, physical, and social development are included. Six of the blind children were considered to be progressing very well; three of the six have some useful vision but the remainder are essentially totally blind. Developmental evaluation in the first year of life is believed to be a valuable adjunct in the evaluation of prematurely born blind children and of particular value to parents and professional workers who aid the parents.

BLIND—DIAGNOSIS

776. Blank, H. Robert *(62 Waller Ave., White Plains, N.Y.)*

Psychiatric problems associated with congenital blindness due to retrolental fibroplasia. *New Outlook for the Blind.* Sept., 1959. 53:7:237-244.

Dr. Blank, who conducts extensive research on the psychiatric aspects of blindness, reexamines etiologic

factors responsible for developmental, behavioral, and emotional problems in both blind and sighted children. In addition, he considers the question of whether the child with congenital blindness due to retrolental fibroplasia presents more psychiatric problems than children congenitally blind from other causes. Congenital blindness per se, he believes, does not produce any specific psychiatric condition but often results in disturbed parent-child relations. Children with retrolental fibroplasia do, however, present more serious psychiatric and educational problems than other congenitally blind children who have no history of markedly premature birth and brain damage. Implications of the findings for over-all treatment are considered. Dr. Blank stresses the need for early guidance and other help for the mother and child during its infancy and the provision of appropriate educational and other resources as the child matures. Research on the development and performance of adolescents with retrolental fibroplasia might provide needed information to aid in management of the young child.

BLIND—PSYCHOLOGICAL TESTS

777. Rothschild, Jacob *(103-10 Queens Blvd., Forest Hills 75, N.Y.)*

A battery of psychological tests in rehabilitation services. *New Outlook for the Blind.* Sept., 1959. 53:7:249-251.

Describes a battery of psychological tests developed at the Long Island Rehabilitation Center, a service facility of the Industrial Home for the Blind, Brooklyn. The selection of tests forms a battery useful in the psychological examination of the blind. Intelligence, manual dexterity, and personality testing provide information for evaluation of blind clients. The battery is administered routinely to trainees during their first or second week at the Center; during this time their subsequent prevocational training is planned.

BRAIN INJURIES

See 776; 796.

BRAIN INJURIES—DIAGNOSIS

See 774.

CAMPING—DIRECTORIES

778. American Camping Association

Directory of camps for the handicapped, prepared cooperatively by American Academy of Pediatrics . . . National Society for Crippled Children and Adults. Martinsville, Ind., The Assn., 1959. (77) p. Mimeo.

First issued in 1957, this revised edition lists camps serving those with orthopedic and neuromuscular disabilities, cardiac impairment, defects of vision, hearing, or speech, diabetes, epilepsy, mental retardation, and social or emotional problems. Only those camps organized specifically to serve the handicapped or that have made special adaptations in their programs are included. Camps meeting the standards of the American Camping Association are indicated.

Copies available from the American Camping Association, Bradford Woods, Martinsville, Ind., or from the National Society for Crippled Children and Adults, 2023 W. Ogden Ave., Chicago 12, Ill., at 50¢ each.

CEREBRAL PALSY

779. Mysak, Edward D. *(176 Eighth St., Newington, Conn.)*

Significance of neurophysiological orientation to cerebral palsy habilitation. *J. Speech and Hear. Disorders.* Aug., 1959. 24:3:221-230.

Conventional and neurophysiological concepts of treatment in the habilitation of spastic cerebral palsy are compared. The general outline and theoretical principles of the Bobath method are described, as well as its application in speech therapy and language development. Much of the cerebral palsied child's speech and language deficits may be viewed as reflecting disturbed phylo-ontogenetic central nervous system maturation. In accordance with the general neurophysiological approach to treatment, goals in speech therapy should be to suppress primitive reflexes, regulate tone, and excite the potential for higher kinds of oroneuromotor activities of which the child may be capable. A pilot study of this approach to treatment is currently being undertaken at the Newington Hospital for Crippled Children; the author has also prepared a film *The Bobath Approach to Cerebral Palsy Habilitation* that is available on request.

CEREBRAL PALSY—SPEECH CORRECTION

780. Byrne, Margaret C. *(4 Bailey Hall, Univ. of Kansas, Lawrence, Kan.)*

Speech and language development of athetoid and spastic children. *J. Speech and Hear. Disorders.* Aug., 1959. 24:3:231-240.

Language development and the articulation skills of 74 cerebral palsied children ranging in age from 2 through 7, all of whom were considered educable, were evaluated. The group consisted of an equal number of athetoids and spastics, with disability ranging from mild to severe and intelligence from retarded to above average. The majority used oral language; the rest depended upon gestures. Methods of testing are described. Data from the study indicated that these children developed first the skills appearing earliest in normal children. All were, however, seriously delayed in the achievement of proficiency in the speech and language items. Spastics achieved higher scores on most of the test items than did athetoids, but differences were not statistically significant. This article is based on a doctoral dissertation completed under the direction of Dr. Harold Westlake. The author is currently director of the Speech and Hearing Clinic, University of Kansas.

CHRONIC DISEASE—PROGRAMS

781. Reynolds, Frank W. *(N.Y. State Dept. of Health, Albany, N.Y.)*

The rehabilitation potential of patients in chronic disease institutions, by Frank W. Reynolds, Maxwell Abramson, and Alan Young. *J. Chronic Diseases.* Aug., 1959. 10:2:152-159.

In same issue: Some comments on "The Rehabilitation Potential of Patients in Chronic Disease Institutions," Martin Cherkasky. p. 160.

Presents data from a survey conducted under the direction of the Bureau of Chronic Diseases and Geriatrics, New York State Department of Health. The rehabilitation potential of 1,480 patients in nursing homes and county

home infirmaries was evaluated; 15.1 percent of those examined were deemed to have definite possibilities for rehabilitation. Slight benefits were considered possible in another 32.8 percent. Over 50 percent were judged unfit for rehabilitation; extent of disability rather than the organ system involved appeared a more important factor limiting rehabilitation potential. Those in county homes were believed to have greater potential than patients in nursing homes. Providing restorative services in county homes has resulted in substantial benefit to residents; in New York State a number of county home infirmaries are currently developing rehabilitation units. Nursing homes should not attempt to become major rehabilitation centers but could provide limited restorative services leading to improved self-care.

Dr. Cherkasky, while lauding the paper as useful statistically, differs sharply with the authors on the need for "chronic disease hospitals." He believes that there *is* need for rehabilitation services in nursing homes where they are closely affiliated with a voluntary hospital.

CLOTHING

See 770.

CONGENITAL DEFECT

782. The National Foundation *(800 Second Ave., New York 17, N.Y.)*

National Foundation Conference on Congenital Malformations, April 5, 1959. *J. Chronic Diseases.* Aug., 1959. 10:2:83-151.

Contents: Introduction to the . . . Thomas M. Rivers.—Congenital malformations in the past, Josef Warkany.—Causes of congenital malformations in human beings, F. C. Fraser.—Experimental studies on congenital malformations, James G. Wilson.—Surgical treatment of birth defects involving the central nervous system, Donald D. Matson.—The problem of congenital malformations; general considerations, Rustin McIntosh.

Papers presented at the Conference discussed the historical background of congenital malformations, the causes of malformations and their experimental production, their surgical treatment as illustrated by the management of congenital malformations of the central nervous system, and, finally, a summary of the problem and suggestions for preventive and therapeutic management.

CYSTIC FIBROSIS—NURSING CARE

783. Fakkema, LaVerne *(Grace-New Haven Community Hosp., New Haven, Conn.)*

How to help the child with cystic fibrosis. *Am. J. Nursing.* Sept., 1959. 59:9:1269-1271.

Describes the role of the nurse in the pediatric chest clinic at Grace-New Haven Community Hospital in working with parents of children with cystic fibrosis. In addition to acquainting parents with various technics for making the child more comfortable, the nurse must learn to help them accept the fact that the disease at present is fatal. The article is illustrated with line drawings of exercises that will benefit the child by permitting him to make better use of his respiratory system.

DEAF

See 767.

DRAMATICS

784. McIntyre, Barbara M. *(245 Melwood Ave., Pittsburgh 13, Pa.)*

Creative dramatics in speech correction, by Barbara M. McIntyre and Betty Jane McWilliams. *J. Speech and Hear. Disorders.* Aug., 1959. 24:3:275-279.

Creative dramatics as an adjunct to speech therapy proved of value in a cooperative program offered by the creative dramatics classes and the Speech Clinic of the University of Pittsburgh. Group speech experiences helped to bridge the gap between the clinic and everyday speech for children with articulation and stuttering disorders who joined in creative dramatics with children who spoke normally. Psychotherapeutic benefits of acting out emotional disturbances are carried over into the area of speech. Creative dramatics can also be used to provide auditory training.

EMPLOYMENT--SOUTH AFRICA

See 768.

EXERCISE

785. Liberson, W. T. *(Hines V.A. Hosp., Hines, Ill.)*

Further studies of brief isometric exercises, by W. T. Liberson and M. Maxim Asa. *Arch. Phys. Med. and Rehab.* Aug., 1959. 40:8:330-336.

A report of the effectiveness of daily brief (6-second) isometric exercises in normal individuals and in patients with lower motor neuron lesions. Results were compared with those obtained from use of the De Lorme exercises. Repeated maximal brief isometric exercises were found to be more effective than single ones (performed only once a day); the effect was particularly noticeable as far as endurance was concerned. Brief histories of patients (6) with poliomyelitis, myotonia dystrophica, progressive spinal atrophy, rheumatoid arthritis, and toxic polyneuritis are included.

HEMIPLEGIA—SPEECH CORRECTION

786. Boone, Daniel R. *(Highland View Hosp., Harvard Rd., Cleveland 22, Ohio)*

Communication skills and intelligence in right and left hemiplegics. *J. Speech and Hear. Disorders.* Aug., 1959. 24:3:241-248.

An article based on the author's doctoral dissertation (Western Reserve University, 1958). A randomly selected sample of 40 right and 35 left hemiplegic patients was studied in regard to variations in basic communication skills, which were then studied in relation to such variables as side of hemiplegia, number of cerebrovascular accidents, intelligence, age, sex, education, and occupation. Aphasic disturbances appeared to be fairly well confined to the right hemiplegic group; left hemiplegics were generally free from marked receptive-expressive language disorders. Intellectual deficits seemed present in most of the subjects studied. Significant differences were found between right and left hemiplegics in all communication skills except for incidence and severity of dysarthria, which was the same for both groups. A battery of six tests, used in the study, is described.

HOBBIES

787. Condon, Margaret E. *(88 Morningside Dr., New York 27, N.Y.)*

Hobby study. *Am. J. Occupational Ther.* July-Aug., 1959. 13:4(Pt. I):171-172, 176.

A questionnaire survey of all handicapped students attending both the uptown and downtown branches of The City College, New York City, was made in regard to their present hobbies. Students were asked to rank hobbies on a preferential scale. Replies received from 84 persons with a wide range of disabilities listed 54 different kinds of hobbies; it was the rare instance when a student had only one hobby. The five most popular hobbies were reading, sports, listening to music, stamps and coins, and writing. It would appear that the recreational world of the physically handicapped is as wide as that of the population as a whole. Handicaps rarely interfere with the enjoyment of hobbies except where disability is sufficient to rule out certain forms of recreation.

A similar article concerning the extracurricular activities of physically handicapped students, written by the same author, was listed in *Rehab. Lit.*, Oct., 1958, #1092.

HOME ECONOMICS

788. May, Elizabeth Eckhardt *(School of Home Economics, Univ. of Connecticut, Storrs, Conn.)*

Suggestions for the rehabilitation of the physically handicapped homemaker. *Am. J. Occupational Ther.* July-Aug., 1959. 13:4(Pt. I):162-164.

Homemaking activities, included in the occupational therapy program, can provide purposeful activity for therapeutic exercise or diversional occupational therapy. Moreover, such activities are a measure of functional ability. Resources for the therapist wishing to incorporate homemaking skills in the rehabilitation program are suggested. The author lists 12 suggestions for therapists that should prove useful in working with the disabled housewife. Includes a page of illustrations showing adaptations to aid in overcoming disability.

MENTAL DEFECTIVES

789. Eastern Psychological Association

Symposium: Research foci in the psychological study of the mentally retarded. *Training School Bul.* Aug., 1959. 56:2:53-76.

Papers presented at a symposium held during the annual meeting of the Eastern Psychological Association, April 4, 1959, at Atlantic City.

Contents: Introductory comments, Anne M. Ritter.—Patterns of sensori-motor skills in retardates, Johs. Clausen.—Discrimination learning in retardates, D. Zeaman.—Research and service synthesis in program development, Ralph W. Colvin.—Discussion, Mortimer Garrison, Jr.

Dr. Clausen discussed a research project in psychological testing of mental retardates at the Vineland Training School. Special training technics used at the Mansfield (Conn.) State Training School were the subject of the paper by D. Zeaman and B. J. House. Dr. Colvin described the development of an integrated treatment and research program at a day-care center for preschool retarded children and their parents. Dr. Garrison, Research Consultant in Mental Retardation to the U.S. Children's Bureau, reviewed the current status of mental retardation research.

790. Training School, Vineland (N.J.)

Practical problems of coordinating and integrating all services related to the treatment, training and management of the mentally retarded; report of conference (held May 11-12, 1959, by the . . .). *Training School Bul.* Aug., 1959. 56:2:31-52.

Presents summary reviews of lectures, panel sessions, and workshops of the two-day conference, cosponsored by the Training School and the New Jersey Department of Institutions and Agencies. Information supplied and used by professional personnel in clinical areas of psychology, psychiatry, education, speech and hearing, daily management of the retarded, medicine, and social work formed the basis of discussions. Specific, desirable practices for coordinating and integrating information to be used by public schools, institutions, clinics, private practice, and agencies concerned with mental retardation were defined.

Contents: Diagnosis; original and continuing, Margaret J. Giannini.—The collection of information (panel discussion).—Recommendations by clinicians, William P. Hurder.—Interpreting and reporting information to using personnel (workshop).—Application of recommendations (workshop).—The team approach to classification and programming (panel discussion).

MENTAL DISEASE

See 796.

MENTAL DISEASE—GREAT BRITAIN

791. Stern, Edward S. *(Central Mental Hosp., Hatton, Warwick, England)*

Operation Rip Van Winkle. *Lancet.* July 25, 1959. 7091:62-63.

Rehabilitation units within the mental hospital, offering industrial, domestic, commercial, and handyman training, have proved highly successful in England. Chronic mental patients are not transferred to the units, however, until socially recovered. Purpose of training is to instill regular work habits and condition patients to normal working situations. Of 61 patients treated in the industrial rehabilitation unit during a three-year period, 29 have successfully made the transition from hospital to the community. Relapse rates have been low.

MONGOLISM

792. Schipper, Martha Taylor *(Gales Child Health Center, 65 Massachusetts Ave., N.W., Washington 1, D.C.)*

The child with mongolism in the home. *Pediatrics.* July, 1959. 24:1:132-144.

Services for the Retarded Child, a facility of the Bureau of Maternal and Child Health, District of Columbia Department of Public Health, offers aid to parents ranging from medical diagnosis of the child's condition to social service casework for families. Observations on 43 children who had mongolism and on family situations and reactions illustrate the impact of the condition on the parents and normal siblings. Dr. Schipper points out how the physician can best serve the child and his family, the more than average support and counseling needed by parents of the mongoloid child, and the medical and

psychological problems of the child. In more than 30 families adjustment to the affected child was accomplished without adverse effect on their way of living. In several families teen-age siblings were more realistic than parents in accepting the assets and limitations of the affected child. This discussion was presented at the 1958 annual meeting of the American Academy of Pediatrics. 47 references.

NEUROLOGY

793. **Voss, Dorothy E.** *(Rm. 310, 1790 Broadway, New York 19, N.Y.)*

Proprioceptive neuromuscular facilitation; application of patterns and techniques in occupational therapy. *Am. J. Occupational Ther.* July-Aug., 1959. 13:4 (Pt. II):191-194.

Occupational therapists should become familiar with the philosophy and principles of proprioceptive neuromuscular facilitation and the specific components of motion and muscles responsible for each pattern of motion. Activities should be adapted so as to allow for the performance of patterns of motion as specific and complete motions. This common approach to therapeutic treatment by both the occupational therapist and the physical therapist will result in maximum benefit to the patient. The rationale of proprioceptive neuromuscular facilitation and its application by occupational therapists are discussed.

See also 779.

NURSING

794. **Rehabilitation.** *Am. J. Nursing.* Sept., 1959. 59: 9:1278-1281.

Contents: A philosophy, George G. Deaver.—The bed patient, Mary M. Jerome.—The ambulatory patient, Winnifred E. Taylor.

Three brief articles explaining the fundamental concepts of a rehabilitation program and elements of rehabilitation nursing. Dr. Deaver *(400 E. 34th St., New York 16, N.Y.)* emphasizes that the groundwork for rehabilitation must be laid while the patient is in the hospital. It is the nurse's responsibility to help prevent deformities and to encourage and teach self-help activities. Miss Jerome discusses ways of motivating the bed patient to achieve his maximum potential through rehabilitation. Because the nurse is in constant contact with patients, she is able to provide understanding and support for the patient with long-term illness. Nursing technics helpful in working with the ambulatory patient and his family include the planning and teaching of self-help activities. Miss Taylor points out that education of the ambulatory patient is vital to his continuing progress in the rehabilitation program.

See also 769; p. 290.

OCCUPATIONAL THERAPY

See 793.

OLD AGE—NEW JERSEY

795. **Public Health News,** N.J. State Dept. of Health. Aug., 1959. 40:8.

Title of issue: The senior citizen in the community.

Contents: Governor's Conference on Aging; opening remarks, Lloyd B. Wescott.—The senior citizen as seen from a governor's desk, Robert B. Meyner.—The legislature looks at the senior citizen, Walter H. Jones.—Growing older—and still growing, Belle Boone Beard.—Accent on health, David E. Price.—Housing our senior citizens, M. Carter McFarland.—Enough to live on, Wilber J. Cohen.— What we have and what we need in New Jersey, Eone Harger.—Good health for the senior citizen, Henry A. Davidson.—The high cost of medical care for the aged, Solomon Geld.—Time not to retire, Robert H. Gaede.—Housing for older persons, Louis Danzig.—Plan young to grow older, Phyllis Bradshaw Greer.—Financial security for older people, Joseph B. O'Connor.—How to form a senior day center, Claude L. Peake.

The first seven papers were presented at the Conference, held in Trenton in April, 1959. Remaining papers, prepared prior to the Conference, were widely distributed to orient participants on all aspects of aging.

PARENT EDUCATION

796. **Klebanoff, Lewis B.** *(4 Marlboro Rd., Lexington, Mass.)*

Parents of schizophrenic children, Workshop, 1958: I. Parental attitudes of mothers of schizophrenic, brain-injured and retarded, and normal children. *Am. J. Orthopsychiatry.* July, 1959. 29:3:445-454.

Characteristic attitudes of mothers of schizophrenic children toward child rearing and the family were studied in an attempt to determine whether these mothers are attitudinally different from mothers of brain-injured children. Findings that mothers of schizophrenic children showed less rather than more pathological attitudes than mothers of the brain-injured and retarded throw some doubt on the concept that maternal attitudes cause schizophrenia. The testing instrument used in the study appears to be useful and, with further refinement, should be able to discriminate with increased effectiveness. The etiology of childhood schizophrenia continues to present a difficult problem: both the organic and psychological approaches should be explored further.

Other papers presented at the Workshop were: 2. The family of the "schizophrenic" child, Aaron H. Esman, Martin Kohn, and Lawrence Nyman. 3. Four types of defense in mothers and fathers of schizophrenic children, Irving Kaufman (and others).

Dr. Klebanoff's paper is part of a doctoral dissertation in clinical psychology, Boston University. The second paper is a report on an outpatient project in the treatment of schizophrenic children at Madeleine Borg Child Guidance Clinic, New York City. The third reports research conducted at the Judge Baker Guidance Center, Boston.

PHYSICAL EDUCATION

See 761.

PHYSICAL EFFICIENCY

797. **Koven, Leo J.** *(60 Plaza St., Brooklyn 38, N.Y.)*

A general capacities scale for children with neuromotor handicaps, by Leo J. Koven and Raymond Rowe. *Am. J. Occupational Ther.* July-Aug., 1959. 13:4 (Pt. I): 166-167, 176.

Describes an evaluation scale used in health conservation units of the New York City public schools serving handicapped children with neuromuscular involvement. The profile was developed for the purpose of providing a quick, accurate summary of a child's abilities—how he functions intellectually, communicates with others, assists himself, and moves within his environment. It is sufficiently general to be practical while providing specific knowledge rapidly when needed. Intelligence, ambulation, activities of daily living, and verbal communication are evaluated but detailed information, such as that found in routine records, is omitted. Rehabilitation units may find the scale useful in evaluation, notation of progress, summary, survey, and prediction of prognosis.

PHYSICAL EXAMINATION

See 766.

PHYSICAL THERAPY

See 785; 793.

POLIOMYELITIS—MEDICAL TREATMENT

See 805.

PSYCHIATRY

See 764.

PSYCHOLOGICAL TESTS

See 762.

PUBLIC ASSISTANCE

798. Haggard, E. B. *(5914 N. Emerson Ave., Indianapolis 20, Ind.)*

The physician's role in the social security disability program. *J. Ind. State Med. Assn.* Jan., 1959. 52:1:83-89.

As medical consultant to the Indiana Division of Vocational Rehabilitation's OASI Determination Section, Dr. Haggard prepared this article for physicians in Indiana, nearly all of whom are involved in processing these cases. Information from material prepared by the Social Security Administration is condensed to include explanations of pertinent provisions of OASI disability regulations and the role of the state vocational rehabilitation agency in making determinations of disability.

REHABILITATION

799. American Public Health Association *(1790 Broadway, New York 19, N.Y.)*

Disability; cash benefits versus rehabilitation. *Am. J. Public Health.* Aug., 1959. 49:8:1082-1084.

A statement prepared by the Medical Care Section and Committee on Medical Care Administration of the Association, representing their thinking in regard to certain problems and needs in rehabilitation. Ideally, it is believed that disability compensation and rehabilitation should complement each other. Conflicting views of disability and legal proceedings work against the concept of rehabilitation. Cash benefits cannot replace the rehabilitation services, but there are many cases where rehabilitation is not feasible. Some practical recommendations for a solution of conflicting concepts are offered.

800. Neu, Harold N. *(407 S. 16th St., Omaha 2, Neb.)*

The challenge ahead in rehabilitation medicine. *Neb. State Med. J.* Mar., 1959. 44:3:101-106.

Sociological and economic problems have been created by the very advances in medicine that have helped to prolong life through the control of acute diseases. National surveys attest to the growing number of the disabled; the challenging responsibility of the future lies in the rehabilitation of adult patients, particularly those between the ages of 20 and 64. Responsibilities for patients over 65 years of age impose added burdens on the population as a whole. Increased demand for rehabilitation services calls for reevaluation of medical school curricula, an expansion of rehabilitation services in general hospitals, cooperation among physicians, hospitals, and other resources in the community, and development and support of specialized rehabilitation centers. Dr. Neu suggests ways of meeting the needs of temporarily or permanently disabled persons and the aged. Leadership and guidance should be accepted by the medical profession as its role in rehabilitation.

801. Whitehouse, Frederick A. *(44 E. 23rd St., New York 10, N.Y.)*

Basic concepts in comprehensive rehabilitation. *J. Rehab.* May-June, 1959. 35:3:4-6, 18.

A philosophical discussion of the concepts—ethical, religious, and scientific—that have contributed to the development of the rehabilitation concept. Inadequacies do exist, however, in total planning for the disabled in society; community responsibility for the provision and maintenance of adequate rehabilitation facilities has been lacking. An excerpt from Mr. Whitehouse's article appeared in *Rehab. Lit.*, Aug., 1959, p. 226.

See also 763; 794.

REHABILITATION—ADMINISTRATION

802. Benney, Celia *(Altro Health and Rehab. Services, 71 W. 47th St., New York 36, N.Y.)*

Integrative aspects of rehabilitation. *J. Rehab.* May-June, 1959. 35:3:13-15, 24-25.

A discussion of integrative aspects of rehabilitation on four levels—interagency, interprofessional and intra-agency, family, and individual. Cooperation between agencies is necessary in any integrated plan of services; rehabilitation agencies and centers often take the lead in planning since they do not have the resources to fill every need. Illustrations of professional interactions and methods used in working with families of rehabilitation clients or the individual client to help resolve the medical, social, and vocational problems are included.

803. Moore, Pamela

Casualties in rehabilitation. *J. Rehab.* May-June, 1959. 35:3:10-12.

A medical social worker at a rehabilitation center examined case records of five patients who failed to cooperate in the rehabilitation program. Certain factors common to all were discovered. Each of the five came from a marginal economic group in a small community dependent for prosperity on the payroll of an industrial plant. Their work histories were unstable; psychological

tests suggested dull normal intelligence. Motivation was not high among the group and immaturity and lack of insight were evident. The rehabilitation center team, and especially the referring agency worker, should work with prospective clients of the center before they are admitted.

REHABILITATION CENTERS—SOUTH AFRICA

804. Andrew, M. L. N. *(Workmen's Accident and Rehab. Centre, Clarendon Circle, Johannesburg, S. Africa)*

The Workmen's Accident and Rehabilitation Centre, Johannesburg. *Rehab. in S. Africa.* June, 1959. 3:2:61-68, 88, (109).

Describes in detail the organization and administration of the Centre, a private nonprofit company set up to deal with industrially injured workers under the Workmen's Compensation Act of 1941. Administration is based on what is known as the open panel system, the Centre being one of the few medical rehabilitation facilities in the world that are run along these lines. The injured workman has a free choice of medical advisor and the medical center where he wishes to be treated. Comprehensive services provided by the Centre are described.

RESPIRATION

805. Walley, R. V. *(Ham Green Hosp., Bristol, England)*

Assessment of respiratory failure in poliomyelitis. *Brit. Med. J.* July 25, 1959. 5142:82-85.

Respiratory failure is the chief danger to life in the patient with poliomyelitis; successful treatment calls for accurate assessment of respiratory function. In treating 62 cases of respiratory and bulbar paresis at Ham Green Hospital over the past five years, standard methods of studying respiratory function were used. This paper describes the methods and their use in clinical assessment. Spirometry, used principally to measure vital capacity and tidal air, has been found the most valuable of technics to estimate respiratory function in poliomyelitis.

SHELTERED WORKSHOPS—CALIFORNIA

806. Aid Retarded Children, San Francisco

Second progress report, Aug. 15, 1958—June 1, 1959 . . . Work-Training Center, a project of . . . San Francisco, The Center, 1959. various paging. tabs. Mimeo.

Sponsored by Aid Retarded Children, a parent association, the Work-Training Center is a demonstration project receiving funds from the Office of Vocational Rehabilitation for a three-year period. The First Progress Report covered a period from November, 1957, to August, 1958, and described rehabilitation services offered. Significant data in regard to population characteristics and population movement, productivity of trainees, savings to the state, services rendered, financial aspects, research developments, and future plans are presented in the current report. Probably the most significant finding is the growing evidence of the possible productiveness of the mentally retarded as a group. Comparing data from the two reports, the staff found no appreciable change in the intelligence level of enrollee groups during the two periods covered. Serious emotional, social, and medical problems of many enrollees contribute to their present inability to obtain and hold jobs in the community. Productivity has increased consistently, however. Recommendations are made for the continuation and expansion of such programs since services of this type are urgently needed.

The report is issued by Aid Retarded Children, 1362 9th Ave., San Francisco, Calif.

SHELTERED WORKSHOPS—ADMINISTRATION

807. Carruthers, F. *(Sheltered Employment Factory, Springfield, Johannesburg, S. Africa)*

Mechanization in a sheltered employment factory. *Rehab in S. Africa.* June, 1959. 3:2:95-102, 78.

The first five years' experience with sheltered workshops in South Africa proved that inadequate mechanization of production methods was handicapping disabled employees. It was finally recognized that employment of the disabled is an industrial welfare problem rather than one to be handled under social welfare agencies. Production in sheltered employment during the next five years following extensive mechanization has doubled. Administration of the sheltered shops, known as factories, is discussed and adaptations in machinery illustrated.

SOCIAL SERVICE—SOUTH AFRICA

See 765.

SPECIAL EDUCATION

See 797.

SPEECH CORRECTION

808. Johnson, Wendell *(Dept. of Speech Pathology and Audiology, State Univ. of Iowa, Iowa City, Iowa)*

Problems of impaired speech and language. *J. Am. Med. Assn.* Aug. 22, 1959. 170:17:2102-2103. Guest editorial.

A brief review of current estimates of the incidence of speech problems, the medical and nonmedical aspects of speech disorders, the role of speech pathologists and audiologists, types of services and the setting in which they are administered, and the physician's need to understand speech problems. Because speech and language are bodily processes, disorders in this area can affect other bodily functions. Dr. Johnson believes that even minor speech problems should be recognized and treated.

See also 774; 784.

STRABISMUS

809. Dunlap, Edward A. *(525 E. 68th St., New York 21, N.Y.)*

Management of strabismus. *G.P.* Aug., 1959. 20:2: 125-139.

The section of *G.P.* devoted to practical therapeutics publishes articles by members of well-known medical faculties. This is the second of 12 articles to be contributed by Cornell University Medical School. The general practitioner, because he is usually the first to be consulted by parents of the child with strabismus, needs to understand the value of early aid. Discussed are etiology, diagnosis, and treatment in children and adults.

STUTTERING

810. Sander, Eric K. *(11206 Euclid Ave., Cleveland 6, Ohio)*

Counseling parents of stuttering children. *J. Speech and Hear. Disorders.* Aug., 1959. 24:3:262-271.

Conclusions and suggestions in regard to counseling with parents of children who stutter are drawn largely from a study of the research and interviews recorded by Wendell Johnson, author of *The Onset of Stuttering* (see *Rehab. Lit.*, May, 1959, #356). Literature in the field was also reviewed. The speech clinician should provide parents with essential information on stuttering and early speech development. Where parents can learn to describe the speech behavior of their children, separating fact from inference, the clinician can help them to eliminate environmental pressures that disrupt the fluency of the child's speech. Methods to be used in parent education are discussed.

ULTRASONICS

811. Friedland, Fritz *(V.A. Hosp., Boston 30, Mass.)*

Ultrasonic therapy. *Am. J. Nursing.* Sept., 1959. 59: 9:1272-1275.

Ultrasound, if used skillfully, can be a safe therapeutic agent superior to other forms of thermal therapy in a number of clinical conditions. Background information on the physics of acoustic energy, the physiological effects of ultrasonic therapy, and its clinical applications is given. Contraindications for this type of therapy are the same as those for heat. Dosage and treatment technics are discussed briefly. Practical application of ultrasound in neurosurgery and as a diagnostic device appears to be promising. 14 references.

VOCATIONAL GUIDANCE

812. Phillips, Waldo B. *(Los Angeles County Bur. of Public Assistance, Los Angeles, Calif.)*

Counseling; a special service in public assistance. *Voc. Guidance Quart.* Summer, 1959. 7:4:214-218.

A report of the experimental use of nondirective counseling with a group of clients of the Los Angeles County Bureau of Public Assistance. The value of counseling as a special service of such agencies was investigated in the hope that it might prove to be an aid in returning applicants to self-supporting social roles. Research methods are explained and a case history illustrates the technics used in counseling. It was concluded that positive attitudes can be developed and the client can gain direction toward an independent pattern of behavior if he is able to experience counseling in a neutralized atmosphere.

VOCATIONAL GUIDANCE—PERSONNEL

813. Rosse, A. Arthur *(Massachusetts Rehab. Commission, 37 Court Sq., Boston 8, Mass.)*

Comparative salaries: vocational rehabilitation counselors, vocational disability examiners. *Voc. Guidance Quart.* Summer, 1959. 7:4:235-237.

Because the position of vocational disability examiner has only recently become a part of state agency administration, the author surveyed public agencies making disability determinations in 50 states and Puerto Rico. Information in regard to salaries, both starting and maximum, for the position was sought. Rationale for salary classification and parity of the position with that of vocational rehabilitation counselor was also investigated. It is recommended that a definitive job analysis be written for the position, outlining functions to be performed and the qualifications required of applicants for the job. Mr. Rosse does not discuss here the functions and qualifications required for the position of disability examiner.

WORKMEN'S COMPENSATION

See 766; 771; 799.

(Continued from page 310)

will undoubtedly prefer the Canadian pattern. Labor will reemphasize its interest in workmen's compensation in this and coming years. Beset as it is by unscrupulous characters within and without, it remains to be seen how much it can bring to bear on this humanitarian cause.

No national conference on improving workmen's compensation has ever been called, even though our leaders in the Association in 1951 and again in 1955 strongly urged the calling of such a conference. One might almost conclude there is a conspiracy of silence. The black hand of negative actions seems all too dominant. The choice we are to make—continuing workmen's compensation on an insurance principle by up-dating our laws or the gradual merging of workmen's compensation with the general welfare program due to pressures that will build up—is a decision that will not be made directly or knowingly. Time at present is on our side, as in the United States the general welfare program is not yet as complete as in England. But a decade passes swiftly and time can run out.

We see all about us the living expression of our collective social conscience—Old Age and Survivors' Insurance, Unemployment Compensation, the state-federal program of vocational rehabilitation and many other humane and decent programs. Only workmen's compensation, the first social insurance program enacted into the law, remains comparatively neglected.

I fear that workmen's compensation is too enmeshed in controversy, confusion, and selfish motives for us on the firing line to solve the problem. We need unbiased leadership from some great spiritually motivated philanthropy such as the Rockefeller or Ford foundation that can rise above controversy. We must believe in the innate goodness and sense of fair play of human beings.

Revised Guide for Interviewing Tubercular for Employment Issued

THE BUREAU of Employment Security of the U.S. Department of Labor has released a revised edition of its interviewing guide on pulmonary tuberculosis, one of the series *Interviewing Guides for Specific Disabilities*. This 1959 edition, reflecting the latest developments in the treatment and employment of persons with tuberculosis, retains the series format, sections being: Description of the Disability; Evaluation of Work Capacity; Definitions; and Cooperating Agencies. Copies may be obtained from the Supt. of Documents, U.S. Govt. Printing Off., Washington 25, D.C. (5¢ per copy; 25% discount on 100 or more).

Recorded Edition Available of *New Outlook for the Blind*

THE PERIODICAL *New Outlook for the Blind* is now published in three editions, inkprint, braille, and on 16⅔ rpm records. The new recorded edition will also be issued 10 months a year and will carry an annotated listing of new talking books, replacing the quarterly *Talking Book Topics*. Subscriptions are available to both the blind and nonblind; the price of the new edition is $5.00, payable to the publisher American Foundation for the Blind, 15 W. 16th St., New York 11, N.Y.

Dr. Willis J. Potts Comments on

The Heart of a Child

"THE MYSTICAL heart of a child is a precious and beautiful thing. It is marred only by wounds of a thoughtless and not too intelligent world. In a physical sense the heart is a tough organ, a marvelous mechanism that, mostly without repairs, will give valiant pumping service up to a hundred years. In an emotional sense it is susceptible to wounds of indifference, thoughtlessness and neglect, and during episodes of illness is especially vulnerable. The heart of a child is mysteriously molded by parents, teachers, playmates and all those with whom it comes in contact. Physicians wish during those short but violent episodes of illness to avoid wounds that will leave irreparable scars. I am convinced that the heart of a child sunned by love, security and understanding will be able to withstand the storms of illness and pain."—*From "The Heart of a Child," p. 16, in* The Surgeon and the Child, *by Willis J. Potts, M.D., W.B. Saunders Company, Philadelphia, Pa. 1959.*

L. J. Linck Appointed NAMH Executive Director

LAWRENCE J. LINCK was appointed, effective Sept. 1, 1959, executive director of the National Association for Mental Health. Mr. Linck was executive director of the National Society for Crippled Children and Adults (1945-1956), executive director of the Illinois Commission for Handicapped Children (1940-1945), and director, University of Illinois Division of Services for Crippled Children (1941-1945). Since 1956 he has been a professional management counselor with offices in Chicago.

Gallaudet to Sponsor Research on Performance of Deaf Students

FOR THE NEXT two years Gallaudet College will sponsor a new research project on the deaf under a grant of over $11,000 from the U.S. Office of Education. A comparative study of the psychoeducational performance of day students and resident students in residential schools for the deaf will be conducted by Dr. Stephen P. Quigley, director of the Central Index of Research on the Deaf at the College. Dr. Robert Frisina, director of the College's hearing and speech center, will assist.

Senate Hearings on Aging Published

THE TESTIMONY received from a panel of expert consultants June 16-18 by the Subcommittee on Problems of the Aged and Aging, U.S. Senate Committee on Labor and Public Welfare, has been published. Available from the Subcommittee Chairman Senator Pat McNamara (U.S. Senate Office Bldg., Rm. 249, Washington, D.C.) is the complete transcript of statements and discussions, as well as a summary report. The sessions centered on employment of the older worker, housing and living arrangements, health, and income maintenance and financing of medical care.

Chairman McNamara has announced that meetings will be held with older persons across the nation during October through December. As of Aug. 20 the following hearings were scheduled: Boston, Oct. 13-14; Pittsburgh, Oct. 23; San Francisco, Oct. 28-29; Grand Rapids, Nov. 16-17; Miami, Dec. 1-2; and Detroit, Dec. 11-12. A hearing was also planned for West Virginia, probably in Charleston. Other members of the Subcommittee are Senators John F. Kennedy (Mass.); Joseph S. Clark (Pa.); Jennings Randolph (W.Va.); Everett M. Dirksen (Ill.); and Barry Goldwater (Ariz.).

Parking Courtesy Extended to Physically Handicapped

THE ISSUANCE by the Registrar of Motor Vehicles of distinctive auto tags to severely disabled drivers is now authorized in Massachusetts. Special plates for free parking in metered areas are also permitted. Special windshield stickers for free parking and meters designated for use of physically handicapped are used in Joplin, Mo. Springfield, Kansas City, and St. Louis also have similar parking areas.—*From* NEPH Newsletter, *Sept., 1959.*

Dr. H. Robert Blank Comments on

Retrolental Fibroplasia and Brain Injury

"FROM MY EXPERIENCE and the study of the experience of others, the following clinical conclusions have emerged which I am presenting to you as working hypotheses susceptible of more scientific validation:

"1. While RLF is not inexorably associated with brain damage or psychiatric disorder, the incidence of severe ego defects and autistic and motility disturbances is far higher among children with retrolental fibroplasia than among congenitally blind children without brain damage who were born full-term.

"2. The incidence of these severe personality problems among the blind prematurely born with brain damage, but without retrolental fibroplasia, is probably as high as among those with retrolental fibroplasia.

"3. The incidence of these problems among visually normal children with brain damage, *e.g.*, cerebral palsy, and with a history of two- to three-months premature birth is almost as high as among the blind with retrolental fibroplasia. . . .

"4. The factors chiefly responsible for the high incidence of these problems among the blind with retrolental fibroplasia are those stemming from *premature birth* and *brain damage*. By brain damage associated with retrolental fibroplasia is meant either: a) Damage to the brain produced by the same pathology causing the ocular damage; b) Damage due to other causes associated with marked prematurity, *e.g.*, congenital malformation or hemorrhage due to capillary fragility; or c) Combinations of the above."—*From "Psychiatric Problems Associated with Congenital Blindness Due to Retrolental Fibroplasia," p. 237-238, by H. Robert Blank, M. D., in* The New Outlook for the Blind, *Sept., 1959.*

Diagnostic Test for Aphasia Developed

A NEW DIAGNOSTIC test for aphasia will be released for general use in November. The test was developed over three years by research teams led by Professors Joseph M. Wepman, University of Chicago Speech and Language Clinic, and Lyle V. Jones, Psychometric Laboratory, University of North Carolina. The Neurological Diseases and Blindness Study Section, U. S. Public Health Service, and the Office of Vocational Rehabilitation gave support for the test's development at the two universities.

In the test a metal box projects simple line drawings and words on an 8-by-12-inch screen, somewhat as in television. The nature of the aphasia is disclosed by the patient's ability to name the picture or word, to match the picture with a projected word, to use the word in a sentence, and to respond to the therapist's spoken questions. The test can disclose specific aphasic defects, as inability to use certain areas of vocabulary or to use words in proper grammatical sequence.

Drs. S. J. Wikler and T. Hale Comment on

Significant Lack of Research on Chronic Foot Disease

"MORE THAN $700,000,000 has been assigned for research on the cause of chronic disease in the past ten years. Postural disability for foot trouble could be an important influence in chronic disease. To the best of our knowledge, after examining the literature, not one small financial grant has been allotted to determine what causes the common disabled foot arch. In the vast National Institutes of Health, for example, where the causes of chronic and stressful disease are under study, there does not appear to be a single investigator who is interested in the foot.

"The authors believe that modern shoes are the overwhelming basic cause of foot trouble. Others have opposed views. Which are true? But in any event we cannot prevent foot trouble until people are confident of its causes. A review of the literature indicates:

1. There is little agreement about the causes of 'fallen arches,'

2. None of the current theories is widely accepted,

3. A comprehensive exploration for the cause of this condition has never been attempted in the United States.

"We suggest that a comprehensive research effort by the national health agencies or by privately endowed institutions is clearly indicated if we hope to conclusively solve the enigma of so many 'fallen arches' in our times."—*From "Is the Cause of Pes Valgo-Planus ('Flat Feet') Unknown?" by Simon J. Wikler, D.S.C., and Thomas Hale, Jr., M.D., in* Military Medicine, *August, 1959, p. 597.*

D. W. Guilfoil Becomes PVA President; M. G. McGee Reelected NPF President

THE UNANIMOUS choice for president of the Paralyzed Veterans of America at the annual meeting of the PVA in July was Dwight W. Guilfoil, Jr., of Franklin Park, Ill. He will serve until the 1960 convention. Mr. Guilfoil, a paraplegic, is president of a Franklin Park manufacturing firm employing only the handicapped.

Morris G. McGee was unanimously reelected president of the National Paraplegia Foundation. Mr. McGee has accepted a position in the English department of Montclair (N.J.) State Teachers College.

Nursing Home Guides Approved by ANHA and AMA Council on Medical Service

THE AUGUST 1959 ISSUE of *Chronic Illness Newsletter* reproduces a set of suggested guides for medical care in nursing homes and related facilities developed jointly by the American Nursing Home Association and the Council on Medical Service of the American Medical Association. The guides, "Nursing Homes with Skilled Nursing Care and Nursing Homes with Skilled Nursing and Personal Care" and "Homes for Personal Care and Homes for the Aged," were prepared to aid administrators and to assist physicians using such facilities. Copies of the guides may be obtained from the Council on Medical Service, AMA, 535 N. Dearborn, Chicago 10, Ill., or the American Nursing Home Association, 1346 Connecticut Ave., N.W., Washington, D.C.

E. H. Watson Comments on

The Family Physician and the Mentally Retarded Child

"IN GENERAL MEDICINE as in pediatrics, the nature of practice has changed fairly rapidly in a generation. Less and less time is spent in treating acute infections and their sequelae, and more on diagnosis and management of anomalies and handicaps. In this connection, the physician must become a counselor to the family. In some instances, the family and afflicted child can be referred to a surgical specialist, as in the case of congenital heart disease. If, however, there is no present treatment, as in cases of mental deficiency, the physician cannot simply present the family with the diagnosis and send them away. Parents expect the physician to have knowledge and advice of kinds not fully covered in medical school curriculums. Physicans should not leave the parents to the care of semiprofessional counselors, but rather should, I believe, accept the role of chief counselor, enlisting help from specialties as needed."—*From "The Family Physician and the Mentally Retarded Child," by Ernest H. Watson, M.D., in* Postgraduate Medicine, *March, 1959, p. 301.*

Dr. Frank Krusen Appointed OVR Special Assistant

DR. FRANK H. KRUSEN in September became assistant for health and medical affairs to the director of the Office of Vocational Rehabilitation. He is on leave of absence for three months from the Mayo Clinic. Dr. Krusen will advise the director on long-range medical programs, policies, and plans related to OVR's current and expanding plans for rehabilitation. Dr. Krusen will work with leading medical groups in interpreting objectives in vocational rehabilitation and will maintain liaison with interested national and international voluntary agencies and also with Congressional committees, the National Medical Advisory Committee, and the Public Health Service.

Social Security Disability Coverage Earned by New Group in October

OCTOBER, 1959, WAS important for many who were first covered by Social Security in 1955, as those becoming eligible for coverage in January, 1955, could have earned disability protection by completing 5 years, or 20 quarters, of coverage. This group of people includes agricultural laborers, domestic employees, and self-employed ministers, accountants, architects, funeral directors, and professional engineers. Disability protection is vitally important since: 1) cash disability benefits are provided for disabled workers 50 to 65 years of age and their dependents; 2) disabled workers under 50 years of age can "freeze" their social security records to protect their own and their families' future benefit rights; and 3) cash disability benefits are provided for the adult disabled children of retired or deceased workers.

The disabled person's right to disability benefits, at age 50, or to the "freeze" provision, under age 50, is based on both the requirement of having 5 years of work out of the 10 years preceding disability and on the disabled person's meeting the definition of disability. The disabled person does not have to be completely helpless, but his disability must be so severe that it prevents his doing any kind of work. Such conditions must have lasted at least six months. Detailed information can be obtained from any local Social Security office. The disability provisions are described in the OASI booklet *If You Become Disabled.*

Revised Checklist of Rehabilitation Publications in Print Available

A SELECTIVE checklist of publications in print *Books and Pamphlets on Rehabilitation,* compiled by the Library of the National Society for Crippled Children and Adults, was revised in August and is available free of charge from the Library. The bibliography lists 136 books and pamphlets and includes prices and publishers' addresses.

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